Maternal and Child Health Services
Title V Block Grant

State Narrative for Northern Mariana Islands

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Signed copies of Assurances and Certifications along with the Orgranizational Chart and the Maternal and Child Health grant application are on file at the Division of Public Health. All Division staff have knowledge of this information and have access to the files. MCH Block Grant narrative and 2010 Needs Assessment Report is also available to the public.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

MCH Program works with its internal and external partners to solicit public input. As will be stated in the following narrative, MCH Program staff serves as members of committees/councils/boards of agency partners that work together to improve outcomes for MCH population groups. These include the Head Start Health Services Advisory Committee, Public School System's Early Intervention Services Program Interagency Coordinating Council, the Governor's Council on Developmental Disabilities, Connecting Families, Inc., Non-Communicable Diseases committee, Early Childhood Comprehensive System Partners, etc. We worked with these communities to conduct the Title V 2010 needs assessment by getting input from the target population they serve

We provide the community with information such as health status indicators, national and state performance and outcome measures, and survey results through print media. Contact numbers and email address are included to encourage input. We also go to villages to meet with leaders such as parish councils. The Department is working to implement its own website but one strategy for the MCH Program is to put out information on partners website such as WIC Program.

We also conduct focus groups, talk story session, interviews with key informants to assist us identify priority needs and also assess our capacity and identify opportunities to work with to expand our capacity to address priority needs. MCH also participates in other partners work to identify priorities. Lastly, we went out into the community during Walk-on-Wednesdays, Marianas March Against Cancer, Sabalu Market, Wise Women Village Project to talk to mothers, pregnant women, parents on ranking priorities.

CNMI state point of contact for grants is the Office of Management and Budget -- we do provide the HRSA's Title V web-site address to various agencies.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

CNMI Maternal and Child Health
Five Year Needs Assessment
Executive Summary

As a grantee of the federal Maternal and Child Health Services Title V Block Grant Program, CNMI is required to complete a statewide maternal and child health needs assessment every five years. The needs assessment process outcome is the identification of priority needs for the maternal and child population groups.

The Division of Public Health's Maternal and Child Health Program is responsible to facilitate the needs assessment process and administers MCH grant funds. The mission of the Division is "To promote the health and well-being of the residents of the Northern Mariana Island by: 1) Protection through sanitation, immunization, and other communicable and non-communicable disease programs; 2) Improving accessibility to care and health promotion and prevention programs; and 3) Empowerment of the community through health education to take responsibility of their health".

The MCH 2010 Needs Assessment includes:

Pregnant Women and Infants
- Case management of high-risk pregnancies
- Increase prenatal care among Medicaid participants
- Increase breastfeeding rates at hospital discharge
- Increase access to pap test service
- Increase access to mammogram service

Children and Adolescents
- Reduce proportion of children aged 12 months to 5 years who are at risk for overweight or obese
- Increase developmental screening
- Decrease birth rate among Chamorro teens aged 15-18 years
- Reduce adolescent risk factors relating to alcohol and other drug use

Children with Special Health Care Needs
- Input information on infants with a diagnosis at birth into the Birth Defects Registry within 6 months

The capacity to addressed each priority needs was also assessed. Short-term strategies were developed on each priority needs. Ongoing evaluation of the priority needs will be conducted so that long-term strategies will be developed. Therefore, we will continue to implement activities, monitor and evaluate results, and make necessary changes to continue to improve health outcomes for our MCH population groups.

The draft priority needs was posted on WIC Program's website, print media, and provided to partners.

III. State Overview

A. Overview

The Commonwealth of the Northern Mariana Islands (CNMI), an archipelago of 14 volcanic islands, is approximately 3,700 miles west of Hawaii, 1,300 miles from Japan and 2,900 miles east of the Philippines. (See Map) The population of CNMI lives primarily on three islands, the major island being Saipan (12.5 miles long by 5.5 miles wide), followed by Tinian and Rota. CNMI became a U.S. Commonwealth in 1975 and its residents (excluding foreign contract workers) are U.S. citizens. The 2000 U.S. Census reported the total population of the CNMI at 69,221 residents with Chamorros and Carolinians (indigenous population) comprising 34% of the total population with approximately 90% living in Saipan. The remaining 66% of the population is comprised of guest workers from the Philippines, China, and other Asian countries; business owners from Japan and Korea; other Pacific Islanders; and Caucasians.

Per the 2005 Household, Income, and Expenditures Survey (HIES), the estimated total population in the CNMI in October 2005 was 65,927. The estimated total population for the island of Saipan was 60,608, Tinian was 2,829, and Rota was 2,490. The estimated median age for the entire CNMI population was 29.2 years of age. Persons in age groups between 20 to 44 years of age made up a relatively larger proportion (48%) of the CNMI's total population than those below age 20 (32%) and those above 44 age groups (20%). This is primarily because of the large number of migrant workers in the CNMI who fall into ages 20 to 44. Total females (53%) outnumbered total males (47%) in the CNMI's total population. The sex ratio (male/female) was 87 males to every 100 females in the Commonwealth in 2005. The largest single ethnic group in the CNMI was Filipino at about 30% of the estimated total CNMI population in 2005, followed by Chamorro (23%) and Chinese (16%). The Carolinians were about 5% of the total population. Asians made up more than half (53%) of the CNMI's total population, Pacific Islanders about 37%, and Caucasian less than 2%. Multiple ethnic persons made up about 8% of the Commonwealth's total population. About 92% (or about 35,400) of the CNMI labor force was employed in 2005. About 8% (or about 3,200) of the CNMI's total labor force population was unemployed in 2005. The median household income in the CNMI in 2004 was $17,138.

The Division of Public Health has expanded its effort to improve community access to primary and preventive health care. This is evident with our satellite clinic in the southern village in Saipan and the school-based clinic located at one of the public high school. Furthermore, Medicaid participants can access health and dental care at 4 private clinics. Some of the Division's initiatives include:

- To lessen health disparities by providing accessible primary care, enhancing disease prevention activities and intensifying public health awareness at the community level.
- To provide sustainable school-based clinics.
- To establish a comprehensive approach to health problems rather than a vertical approach such as more multi-sectored that would include major stakeholders.
- To "delink" structurally and programmatically from the Hospital Division in such areas as data and financial system.
- To develop a data infrastructure unique to the needs of all the programs in the Division.
- To decrease the burden of diabetes such as the high incidence of end stage renal disease associated with diabetes, lower extremity amputations and blindness by detection, management, and education of the community.
- To reestablish environmental health as an integral component in the health care model.
- To build up local manpower capacity for sustainability.

The Institute of Medicine (IOM) has articulated the need to address major health threats and concerns from a multi-level perspective, building partnerships across health systems, communities, academia, business, and the media, in order to effectively improve the health of the population. The MCH Program has been instrumental in forging strong partnerships to enhance disease prevention and public awareness activities. This includes our work with the school system in oral health, nutrition, and physical activity. With oral health we provide fluoride varnish

application at the WIC and Immunization Clinics; oral mouth examinations and fluoride varnish and sealant application on-site at the Head Start Center; and conduct presentations during health symposiums and parent teacher conferences. In addition, we conduct media campaigns and home visits with our partners. Please note that public service announcements such as dates and time of specialty clinics are provided free of charge from the media. The public health nutritionist is visible at all the schools to conduct nutrition and fitness activities. In fact one of the most requested speakers for the elementary school level is the nutritionist. In our work with the community it is recommended to implement activities after working hours or weekends and to go out to the villages. MCH and all the programs participate in community events and also coordinate events at the community level. For example, we implemented our dance sessions to promote physical fitness activity with the Wise Women Village Project in the evenings from 6-8 pm around the villages including Saturdays. There are around 100 women participating in the dance sessions. We hear stories from women that have lost weight, have increased their fitness activity level, have stopped smoking, and have been eating healthier. During community events like the Flame Tree Festival, the women performed a dance number at the event.
We continue to provide preventive services at our school-based clinic since 2004. The clinic is a joint effort between the Division of Public Health and the Public School System to provide preventive services to adolescents in the school environment. Services include health promotion and education, substance abuse and nutrition counseling, and referrals. MCH Program assists with enabling and population-based activities that focuses on working with the students to promote being physically and mentally healthy. We collaborate with the Public School System in our outreach activities to provide adolescents with information and tools in decision making skills and self esteem. Through the Title X Program, a sliding fee-for-service scale is based on the adolescent's own income and insurance status therefore allowing them to qualify for 100% cost coverage. We are currently working with another public high school that has a full-time nursing staff and a health center.

The program's efforts to work with stakeholders is evident with membership in the PSS Interagency Coordinating Council, Connecting Families, Inc., Developmental Disabilities Council, Head Start Health Advisory Committee, Commonwealth Cancer Association, etc. In conducting the 2010 Needs Assessment we have worked with these stakeholders to identify priority needs for their target population. We have also coordinated and consolidated awareness events with our partners. We also work with ethnic groups to assist us with our materials and translations/interpretations. Some of our partners also volunteers for activities such as Reach Out and Read and manning of our exhibits/informational tables. We have established relationships from our stakeholders thus enabling public health programs to so we do get support and corporation when we solicit.

In our efforts to improve our quality of data the Division of Public Health continues to create and implement standalone databases. The system that the hospital uses is called the Resource and Patient Management System (RPMS) and is MUMPS based. RPMS is an integrated solution for the management of clinical, business practice and administrative information in healthcare facilities of various sizes. RPMS was developed by the Indian Health Service and serves as the basis for many related programs, including the Department of Veterans Affairs' VistA system. Since its implementation in 1992 there have been minimal staff training and upgrades made to the system due to lack of state funds. The hospital information technology staff has been keeping abreast of new developments to RPMS through a consultant from Indian Health Services in New Mexico. The staff from CHC received minimal training on some modules for this system. With funding from the SSDI grant, two staff from the Health and Vital Statistics Office has attended Fileman (a report querying module) on the RPMS system. Currently, coding for RPMS is not done in real-time and therefore there is often a six month or longer lag in data becoming available in the system. Because of this, the programs at the Division of Public Health have begun to develop standalone databases or registries to collect more accurate data on our population. In addition, we work to link it with birth certificate database. It has become even more critical to ensure that data can be linked between the systems so that complex data queries can be run. Some of our system includes the EHDI surveillance and tracking system, newborn metabolic

screening database, WebIZ Registry, and we are working with a contractor for the birth defects registry. MCH Program was instrumental in reviewing the information that is on the revised 2003 birth certificate standard form.

MCH Program's work with decreasing the burden of diabetes is focused on gestational diabetes milletus (GDM). We contracted the services of a consultant to assist with the education of GDM to clinical nursing staff including case management; education and counseling is also provided to our pregnant women with GDM. We have reinstated the glucometer loaner service and the nutritionist sees the women the same day as their prenatal care visit. We have supported The Club Hinemelo'ta which is an exercise program for larger women who have diabetes or pre-diabetes; are overweight; and have high blood pressure. We worked with them to implement the exercise program on the islands of Tinian and Rota. MCH also supported the training for the facilitators of the program.

The need to build and improve our current local health care manpower for sustainability of our public health programs is critical to improving delivery of services to our community. This is also more imperative because on November 28, 2009 the federalization of our immigration went into effect. This means that by 2013 all nonresident workers have to go back to their home country. Our effort to build our local manpower goes in line with the strategic plan for future health initiatives stated in the Institute of Medicine (IOM) report. One of the four recommended approaches includes promoting the education and training of the health care workforce (IOM, 1998). We work with health professional education programs and universities to provide the training for this initiative. This includes the MCH Certificate Program from UH JABSOM; University of California Los Angeles Medical Center Women's Health Care Nurse Practitioner Program; University of Texas, Southwestern Medical Program; and the Northern Marianas College (NMC). Through the NMC AHEC program NCLEX review classes are held every year. We are also working with Southern High School on the Nursing Assistant Program. Then there is our collaboration with WHO and SPC to provide various training on developing health education materials, conducting oral health outreach activities, STD counseling, etc. We continue to bring organizations such as Colorado Hands and Voices and Center for Breastfeeding to conduct training on-island. We have staff that has received training or continuing education units online. Our challenge of meeting the health care needs of the CNMI residents within the struggling health care system have made us take into consideration the need to increase and expand our relationship with the private clinics. One of the options that has been mentioned is to expand Medicaid to the private health clinics. This option also improved our work to reduce health disparities by allowing Medicaid participants access to health care that is available at the private clinics. This solution at the same time provided us with the unique challenge of educating our community about seeking care in the private clinics since they were still coming to our clinics. (Please note that prior to February 2008, Medicaid can only be accepted at public health facilities.) This is also one reason why we include Medicaid information on our ad campaigns including information on the private clinics that are participating in the Medicaid program. A poster with this information is also put up at all the public health clinics.

The declining economic situation for the CNMI is highlighted with headlines such as NMI Nutrition Assistance Program seeks $9 million more for food stamps; Over 700 families on government's housing assistance wait list; Habitual offender a problem in the CNMI; Theft case involving youths up; 74 students remain on Head Start's wait list to meet rising food costs; CUC sets power outages; NMI April 2009 visitors arrival down 12% compared to April 2008 (for November 2009 it was 29% less than November 2008); etc. Because of our economic situation, programs at the Division of Public Health have been considerate of the financial situation of families. For example, we have programs such as Wise Women Village Project (WWVP) and the Breast and Cervical Cancer Screening that focuses on the needs of the different ethnic group in our culture taking into account their financial status. Together with our partners, the MCH Program have intensified their referrals by assisting applicants on-site, providing transportation to Medicaid or NAP, and has increased work to provide translation and translators. With assistance from ECCS Big Steps for Little Feet project and Early Hearing Detection and Intervention Program we have

been providing gas vouchers for our families.

We have also been considerate of our community's requests to bring services out to them. Again, this is evident with our partnership with WWVP. The HPV School Campaign created a model for other prevention programs by localizing educational materials and going beyond the clinic-based setting. The focus is on educating parents and high school girls on cervical cancer and HPV vaccine and at the same time provide the HPV vaccine free of charge to all the students in the CNMI.

The development of homestead lots in the CNMI is growing rapidly and is a geographic challenge in reducing health disparities. These homestead lots are both residential and farming community. Majority of the larger homestead lots are located miles away from the nearest health facility - private or governmental. There is no public transportation on the island. This has pose as a challenge for the Division in ensuring the availability and accessibility of services. For example, the Kagman Homestead area is located in the northeast side on the island of Saipan with a population of about 8,000. These are young families living in the area. There is two Head Start Schools, one elementary, middle, and high schools. The nearest health facility is located on the west side of the island which is about 7 miles away. Results from the postpartum survey shows that over 50% of women that lives in either Kagman or Koblerville either had inadequate or no prenatal care. These are two of the villages that WWVP services and Head Start Dental Program are provided. We coordinate activities with all the schools for health activities. We will again submit the Section 330 grant application to open a community health center in Kagman.

The strength of the programs at the Division of Public Health lies in the commitment and dedication of staff.

B. Agency Capacity

The Maternal and Child Health Program is administered under the Division of Public Health. The Program through the Southern Community Wellness Clinic and its partnership with the Hospital's Women and Children's Clinic and the Community Guidance Center provide primary and preventive health services to the community. Services include medical, dental, mental health, substance abuse counseling, women's health, nutrition counseling, and family planning. Our collaboration makes it possible to bring health services out into the community such as the Wise Women Village Project. Our work in every health area is supplemented by enabling services including outreach, case management, educational materials, and transportation to MCH target population. Please note that we collaborate with our external partners to conduct activities in these areas. Some of our population-based activities include Medicaid eligibility assistance for children with special health care needs and the prenatal projects. The strategy is to work with the community so that we can empower the community with tools and information to make informed decisions to live healthier lifestyles. Other strategies to strengthen MCH Program's capacity to promote and protect the health of our target population are: 1) work with schools to ensure children enrolled are up to date with their immunization and on nutrition and physical fitness activities; 2) work with our partners during island-wide community events which will strongly emphasize lifestyle behavioral changes especially with health care practices, diet, and physical fitness; 3) establish a network linkage with other providers to inform them of health news, health alerts, awareness events, training, etc.; and 4) develop partnership with other agencies to ensure continuity of care. To reiterate, the strength of our work is in our collaboration with our partners.

Preventive and primary care services for pregnant women and mothers:
These services are provided at Southern Community Wellness Clinic in San Antonio Village is located in the most southern part of the island of Saipan. Please note that all services provided at the Wellness Clinic include education and counseling in smoking, physical activity, breastfeeding, nutrition, etc. In addition, HIV/STD Prevention Program, Nutritionist, and Community Guidance Center staff come and provides services on-site. Training to clinical staff is

also a collaborative work. These services are also provided at the at the Women's Clinic, Adolescent Health Center, and 5 private health clinics.

- Prenatal care is provided at the Southern Community Wellness Clinic, Women's Clinic located at the Commonwealth Health Center, and Rota and Tinian Health Center. It is also provided at the Adolescent Health Clinic. In addition It is also provided at 4 private health clinics that participate in the Medicaid Program. The first visit involves prenatal first visit intake/interview by nurse, physical exam (pap test), blood work, counseling, including HIV testing. The revisit exams include monitoring baby's growth and development and the mother's condition, and counseling and education. Staffing at the Southern Community Wellness Clinic includes a family practitioner, two women's health nurse practitioners, two nursing assistants, and six registered nurses. There are three OB/GYNs at the Women's Clinic for referrals of high risk cases such as diabetes and hypertension. Prenatal care visits are provided five days a week from 7:30 a.m. to 4:30 p.m. Increasing the percentage of adequate prenatal care visits, especially during first trimester, continues to be a focus for the Division. Another focus area is to have all mothers screened during pregnancy for the following: Hepatitis B, Syphilis, Gonorrhea, Chlamydia, Rubella, Diabetes, Hypertension, Cervical Cancer, Group B Streptococcus, and antibody screening.
- Postpartum Care: Postpartum clinic is held on Mondays, Tuesdays, and Thursdays. Women identified as high-risks pregnancies are provided an appointment to see a doctor one-week postpartum. The six weeks postpartum clinic provides family planning counseling and contraceptives.
- Breastfeeding Clinic: Newborn assessments -- make sure that lungs are clear, weight gain is appropriate, regular rhythm of the heart, condition of cord, check testicles for boys, vaginal discharge. Check mother's breast for nipple sores, engorgement, reinforce breastfeeding techniques. We send two staff to attend a breastfeeding training this year. This service is provided on Mondays, Tuesdays, Wednesdays, and Fridays.
- Family Planning: The primary focus of the Family Planning Program is to reduce the numbers of unplanned pregnancies and the prevention of teen pregnancy. Family planning training was conducted to clinic providers and staff at the Women's Clinic and as of September 2008 the Clinic is another site providing family planning services. This is in addition to the Southern Wellness and Adolescent Health Clinics. Services are provided every day for scheduled appointments and walk-ins.
- HIV/STD Prevention: The HIV/STD Resource and Treatment Center opened in 2002. The center, located away from the Commonwealth Health Center, provides pre and post counseling, partner identification and notification, treatment, and case management. Some goals of the program include opening test sites out in the community and mass media campaigns emphasizing on behavioral change. It works closely with the school system and other community groups to conduct educational awareness activities. Training for staff, including nurses at the public and private sectors, on HIV pre and post counseling is done every two years. Testing is currently done at the Southern Wellness and Adolescent Health Clinics, and the Commonwealth Health Center.
- Breast and CervicalCancer Screening: Breast cancer and cervical cancer screening exams such as pap smears, clinical breast exams, and mammograms are provided to women over 40 years of age at no cost to women that meet the program's criteria. Eligibility assistance and transportation is provided to clients; transportation includes air fare tickets to clients form Rota and Tinian for mammograms. In addition, program staff conducts outreach presentations on early detection and prevention including risk factors. Supplemental activities include providing services at night and free mammograms for one month for all women, and expanded outreach activities with partners such as MCH during awareness months.
- Wise Women Village Project: provides women-focused services and counseling to target groups in the villages with partners.
- Women's Health: Gynecological services -- pap smears and consultations - are provided at the satellite clinics, and Rota and Tinian Health Centers. The referral clinic for complicated cases is the Women's Clinic at Commonwealth Health Center.
- Health screenings such as blood sugar, blood pressure, weight, etc. is provided daily on a walk-in basis. This is also conducted during community events.

Preventive and primary health care services for infants and children:
These services are provided at the Southern Community Wellness Clinic, Children's Clinic, and 5 private health clinics.

- Immunization: The Immunization Program provides the vaccines for children, works with the schools to ensure that all children are up to date with their vaccinations, collaborates with the private clinics to ensure availability and accessibility of service, and overall continue to work to achieve goals and objectives in the measles elimination plan for the CNMI. Immunization is provided at the public health facilities and all of the six private clinics. The basic immunization series includes Diphtheria, Pertussis and Tetanus (DTap), Polio (IPV), Mumps, Measles, and Rubella (MMR), Hepatitis B (HBV), and Hemophilus influenza type b (Hib), Pcv 7, Rotavirus, Pediarix. The staff are tracking children that are not up-to-date and making telephone calls to parents on a daily basis. For those children that have no transportation the nurse goes on home visits to give the shots. Supplemental activities are done during immunization awareness month with extended clinic hours, providing immunization during community events and providing immunization out in the villages. We work with our partners to provide awareness on the importance of age appropriate immunization such as WIC. Walk-in policy has been reinstated. One of the challenges for the Program and other programs is the migratory pattern of our population. In addition, the program is responsible for the issuance of the school health certificate upon completion of immunization. By law, all children are required to be up-to-date on their immunizations before they can enter school.
- Well Baby/Child exams are provided at the wellness clinic and Children's Clinic. The function has been transferred out to the satellite clinic; appointments are made to the Children's Clinic at the parents' request. Services provided include immunization, health education and counseling including nutrition, injury prevention, safety, assessment and monitoring for growth and development and other underlying health problems, and physical examinations. Referrals are also being done such as for dental care, hearing screening, early intervention services, specialty clinics, and home visits. The promotion of breastfeeding is actively done during these visits. Physical examinations include vision and hearing screening. Again, the referral site for complicated cases or for consultation is the Children's Clinic. There are currently three pediatricians. This clinic is held every Mondays, Tuesdays, and Thursdays.
- Newborn Hearing Screening: We have been successfully screening 98% of our babies before hospital discharge. We continue to work with the 1-3-6 model as program benchmarks. We have been focusing our quality improvement activities to reduce our loss to follow-up numbers. We provide annual training to nursing and early intervention services program staff on all component of an early, hearing, detection, and intervention program. The EHDI surveillance system has been instrumental in identifying babies that are not screened for hearing loss and those that do not come back for the second hearing test
- WIC Program:The Special Supplemental Nutrition Program for Women, Infants, and Children - better known as the WIC Program - serves to safeguard the health of low-income women, infants, & children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.
- Outreach Program: This consists of the home visit nurses. The two barriers to the program are first the inadequate numbers of staff to fully attend to the increase load for home visit and transportation.
- School Health Program:

1. A school health certificate is required for all children entering school for the first time in the CNMI. In order to get the school health certificate a physical examination (including hearing and vision screening) is required and they must have completed the required immunization series for that age group. Parents continue to call to schedule physical examinations in late July and August. Physical examination is also provided at the private clinics.
2. School Dental Program: This program has proven to be one of the successful collaboration between the Division and the School System (both public and private) and the parents.

- Head Start Program -- As of 2008, dental assistant go to each Head Start center to provide mouth examination, fluoride varnish and sealant application, and education. The

Program purchases the supplies and Public Health provides the staffing. We have also been scheduling appointments for those children enrolled in the Medicaid Program for their restorative treatment needs. As of February 2009, 4 private dental clinics are accepting Medicaid. This information and Medicaid Program's information is included in all our media campaigns. Every year we conduct oral health presentations during the Parents Health Symposium.

- First, fifth, and sixth, including private schools -- Every school year children in first, fifth, and sixth grades in the public and private schools, including Rota and Tinian, are bussed to the Dental Clinic per an agreement with the public school system. Services provided include mouth examination in which they are assessed for caries and periodontal diseases, sealant application, and education. The children are given report cards on their dental assessments so parents can make necessary appointments for further dental treatment and procedures. The Dental Clinic provides services that include general dentistry such as sealant application, fluoride tablets, education/counseling, community outreach activities, cleaning, extraction, and fillings. With the recruitment of another dental hygienist, more awareness and education on oral health will be provided at the school level. Building up the skills of staff and replacing/upgrading the equipment continues to be a focus of the Dental Unit.
- Mental Health and Social Services: School counselors and other service providers work closely with the staff of the Community Guidance Center for provision of services at the school-based clinic. Staffing includes one psychiatrist, three mental health counselors, two social workers, one prevention manager, one program coordinator, one tobacco coordinator, one health educator, and one health educator assistant.

In addition, the early childhood comprehensive system partners are working together to ensure that children are healthy and ready to learn at school entry. We have increased our public awareness campaign on children's growth and development in collaboration with CDC's "Learn the Signs. Act Early" Campaign. We continue to be a referral source to four private health and dental clinics providing service to Medicaid participants.

Services for children with special health care needs:
The Children with Special Health Care Needs (CSHCN) Program is a component of the MCH Program. Services are set up to promote an integrated service delivery system for CSHCN from birth to twenty-one years of age and their families. We work to ensure that children not only receive specialized health care that they need but that they are up-to-date with their immunizations and that they avail, if qualified, to the different social service programs on island. One priority of the program is to identify these children at the earliest age possible, preferably right after birth. The entry point is a referral to the Early Intervention Services (EIS) Program located at Children's Developmental Assistance Center (C*DAC). In reviewing our data the average age for referral for all children is at 29 months. There are care coordinators, special education teachers, social worker, and occupational, physical, and speech therapists on staff for the 0-3 years old. We have a community health nurse who oversees the coordination of specialty care that our children need. The Program works collaboratively and cooperatively with other agencies and departments to provide appropriate education and support services needed to meet their social, emotional, physical, and medical needs. Specialty clinics, such as Pediatric Cardiology and Shriners, are conducted twice a year, annually, or every other year. We work closely with health care providers and the Medical Referral Program to ensure that our children needing extended care go off-island. We procure contractual services such as the audiologist to provide services to our children. We continue to provide transportation, eligibility assistance, and continue with activities such as parent events, health forums, trainings, etc. We have been working with different support groups such as Deaf and Hard of Hearing, Autism, etc. to implement activities to promote and sustain these support groups.
We continue with challenges for the program that include:

- lack of qualified professionals on-island for specialized services;
- clients who do not qualify for SSI, Medicaid, etc., because of citizenship status
- lack of respite care facility for families of CSHCN -- please note that through the CNMI Developmental Disabilities Council in which the MCH Program Coordinator is a member, we did apply for a Real Choice Systems grant to provide respite care. However, funds are not

enough for everyone and only one provider applied.
• Pediatricians are on a two year contract and we continue to struggle with the shortage of pediatricians. Parents/children get use to one particular provider and after two years he/she does not renew and thus a change in provider. This was one thing mentioned from the survey as far as continuity of care.

We continue to work with our college on training such as the UH LEND Program that provided training to physicians, nursing staff, and early intervention services staff (includes private clinics and Public School System Special Education Program staff) on disability that included cultural aspects, developmental screening, autism, etc. We have been focusing our collaboration with new partners to address needs of our children with special health care needs. One good example of this is last summer the USN 4th Medical Battalion with the lead of Capt. Anita Kobuszewski provided dental care services to children with special health care needs as part of their Innovative Readiness Training mission.

Preventive and primary health care services for adolescents:
Services provided at Adolescent Health Clinic, Women's Clinic, Southern Community Wellness Center, Children's Clinic, HIV/STD Resource Center, and 5 private health clinics.
The Adolescent Health Clinic is a school-based clinic located at one of our largest public high school. The clinic sees an average of 178 students per month. The overall goal of the Clinic is to make preventive health services available to teens while educating them on how to take responsibility for their own wellness. Clinic appointments are often full booked. Other Department staff continues to provide services on-site including Community Guidance Center, HIV/STD Prevention Program, Family Planning Program, etc. One full-time RN staffs the Clinic and other providers are rotated through to provide specialized services. Educational pamphlets on health issues specific to adolescents are readily available and classroom presentations are provided upon request.
The Division has managed to remove the barrier of access to service by meeting teens in their environment thus eliminating disparities. This clinic meets the students in a confidential setting where education and clinical exams are achieved on site. Onsite educational and clinical services in the high school setting allow ease of access, confidentiality, and personal counseling within an environment that is neither restrictive nor intimidating. Students are always encouraged to include their parents or families in decision making especially on sexuality.

HPV School Campaign - During the 2007-08 academic school year, the Immunization Program and its Stakeholders: Breast & Cervical Cancer Screening Program, Commonwealth Cancer Association, Maternal and Child Health Program, Parents and schools (Public & Private) formed a community coalition to provide Human Papillomavirus Vaccine (HPV) to all girls 11 to 18years of age.
We conducted a media campaign in which it received national recognition and award to educate the general public about the extend of the cervical cancer problem in the CNMI, the availability of a vaccine to prevent cervical cancer and details of the school campaign. The goal for the program is to vaccinate all female gender within the age eligible group, to reduce the prevalence rate of cervical cancer in the CNMI. Currently 75.5% of girls enrolled in the public high schools have received all 3 doses of the vaccine.

To enhance our capacity to promote and protect the health of all mothers and childen, including CSHCH we have been building our data infrastructure through SSDI grant for newborn hearing screening, newborn hearing screening and at the present time birth defects database which are linked to birth certificate database These databases allow us to collect data according to different ethnic groups and assist us expand our work with that particular group. We have translated newborn hearing screening materials to Korean and Chinese because in reviewing our numbers they are the ethnic group that refuses the service.

C. Organizational Structure

The Commonwealth of the Northern Mariana Islands (CNMI) is self-governing with locally elected governor, lieutenant governor, and legislature. In 2009, Benigno R. Fitial was re-elected Governor of the CNMI with a new lieutenant governor, Honorable Eloy Inos. Each state agency is under the supervision of the governor and is headed by a single executive. The governor appoints the heads of executive departments with the advice and consent of the Senate. Being a state agency, the Department of Public Health is headed by a Secretary of Public Health. Since 2006, the Department has been guided under the leadership of Mr. Joseph Kevin Villagomez as the Secretary of Public Health. The Secretary is the authorized representative for the Department and serves as a cabinet member. The Department comprises of three (3) Divisions: Hospital Division, Community Guidance Center and the Division of Public Health. Deputy Secretaries for Hospital and Public Health Division is also appointed with the recommendation of the Secretary of Public Health; the Community Guidance Center is under the leadership of a Director. The Medicaid Program and the Medical Referral Program are two line programs that are organizationally structured under the Department of Public Health.

The Department of Public Health is part of the Executive Branch of the CNMI government. PL 1-8, Chapter 12, SS2 give the Department the powers and duties to:

- maintain and improve health and sanitary conditions;
- minimize and control communicable disease;
- establish standards of medical and dental care and practice and to license medical and dental practitioners;
- establish and administer programs regarding vocational rehabilitation, crippled children's services, infant care, Medicaid, Medicare, mental health and related programs including substance abuse;
- establish standards for water quality; and
- administer all government-owned health care facilities.

The mission of the Department is to "Promote the health and well being of the residents of the Northern Mariana Islands by protection through sanitation, immunization, and other communicable and non-communicable disease programs; Improve the quality of life through encouraging and empowering the community to achieve its highest possible level of wellness and; Ensure the availability of efficient and quality health care and prevention services".

A Deputy Secretary that is appointed by the Governor with the recommendation of the Secretary of Public Health oversees the Division of Public Health. Mr. John Tagabuel has been appointed in the acting capacity since October 2008. Dr. Richard Brostrom, Public Health Medical Director, provides guidance to all preventive health programs. The Division of Public Health's mission is twofold:

- To improve the quality of life through empowering and encouraging the community to achieve its highest possible level of wellness;
- Ensure the availability of quality health care and prevention services.

The Division of Public Health is responsible for administering the State's Title V Maternal and Child Health Program - Prenatal and Postpartum Care, including children with special health care needs and other preventive health programs. The State System Development Intiative project (1 staff), Early Childhood Comprehensive System Project (1 staff), and Universal Newborn Hearing Screening/Early Hearing Detection and Intervention (2 staff) are under MCH Program. Other programs in the Division include:

- Diabetes Prevention and Control Program (staffing include Program Coordinator, Administrative Assistant/Tracker, Community Health Specialist)
- Breast and Cervical Cancer Screening Program (staffing include Program Coordinator, Data Management Specialist, Community Outreach Worker, and Administrative & Tracking Assistant)

- Immunization Program (staffing include Program Manager, IMM Info System Administrator, Immunization Clerk (1- Rota, 1- Saipan, 1- Tinian), VFC Coordinator, Staff Nurse, AFIX Outreach Worker, Community Outreach Worker, VPD Tracking Coordinator, Perinatal Hepatitis B Coordinator)
- Women, Infants, and Children's Program (staffing include Program Administrator, Nutritionist, Breastfeeding Services Coordinator, Financial Analyst, Financial Manager, Quality Assurance Coordinator, Vendor Management Coordinator, Administrative Assistant, Nutrition Technician (7), Information Clerk, Nutrition Assistant (2), Clinic Administrative Assistant, Office Manager, System Administrator, Clinic Manager)
- Early Hearing Detection and Intervention (staffing include Follow-Up Coordinator, Data Tracker, and contractual services of Audiologist and Computer Specialist)
- Health Promotion (all Community Outreach Workers from all the Programs)
- Family Planning Program (staffing include Program Coordinator, Nursing Assistant, Registered Nurse)
- HIV/STD Prevention Program (staffing include Program Manager, Community Health Worker, HIV Case Worker, STD Case Worker, Clinical Attendant)
- Comprehensive Cancer Control Program (staffing include Program Coordinator, Data Coordinator, Community Outreach Worker)
- Wise Women Village Project (staffing include Program Coordinator, Case Manager, Community Outreach Worker)
- Office of Epidemiology -- (Epidemiologist)

In addition, the Division administers the Bureau of Environmental Health (11 staff); Early Intervention Services Program (4 staff); Adolescent Health Clinic (1 staff); Public Health Liaison Office (1); Dental Unit (10 staff); Southern Community Wellness Clinic (10 staff) Public Health Emergency Preparedness (2 staff) and Chest Clinic (5 staff).

Other units include Health and Vital Statistics Office (3 staff); Accounting; and Administrative Support Service (4 staff). There are program mangers that oversee these different programs/units. These services are also provided at the Tinian and Rota Health Centers. A Resident Director oversees services provided in Rota and Tinian.

The Department of Finance and Accounting is responsible for the financial management of all funds, both local and federal. The Department is responsible for draw downs, submission of financial status reports, and checking/approving all funds to be used. The Governor's Office approves the expenditures of funds such as personnel, travel, purchase orders, contracts, etc.

An attachment is included in this section.

D. Other MCH Capacity

Key personnel involved in MCH activities include:
Secretary of Public Health: Mr. Joseph Kevin Villagomez, MA was appointed by Governor Benigno R. Fitial to be the Secretary of Public Health in 2006. Mr. Villagomez holds a B.S. in Psychology from Washington State University where he graduated with honors and holds a Masters of Science in Counseling Psychology form Antioch University of New England where he also graduated with honors. Mr. Villagomez established the first ever Substance Abuse Treatment Program and the Substance Abuse Prevention Program in 1993. He has been with the Department since 1992 and he was the former Secretary of Public Health from 1998-2002. He was also the primary reviewer for American Samoa's MCH grant application in 2001.

Deputy Secretary for Public Health Administration (DSPHA): Mr. John Tagabuel was appointed Acting DSPHA by Governor Benigno Fitial in 2008. He was the Chief of Bureau of Environmental Health. He has extensive trainings in food policy, food safety, and food security.

Public Health Medical Director: Richard Brostrom, MD, has been the Public Health Medical

Director since July 2001. He received his medical degree with honors from University of North Carolina School of Medicine. He also received his MSPH from North Carolina School of Public Health. He is a licensed physician and is board certified by the American Board of Family Practice. He currently provides leadership and expertise for the Division's many programs. He continues to provide regular medical care services focusing on women's health, obstetrics, and pediatrics.

Public Health Dentist: Dr. Alberto Ventura, DMD, received his Doctorate degree in Dental Medicine (Cum Laude) from the University of the East, Manila, Philippines. He is licensed by the CNMI Medical Profession Licensing Board, and has been providing his services to the Division since 1982.

Women's Health Nurse Practitioner: Mrs. Luise Q. Noisom, RN, BSN, WHNP, is a nationally licensed Women's Health Nurse Practitioner since 2002. She has been working for the Division of Public Health since 2001; however, she has been practicing as a nurse for the Commonwealth Health Center since 1989. Mrs. Noisom received advanced education and training from a master's certificate Women's Health Care Program at the University of Texas, Southwestern Medical Program in 2000. She provides women's health services at the satellite public health clinic.

Women's Health Nurse Practitioner: Mrs. Bertha Peters Camacho is a nationally licensed Women's Health Nurse Practitioner since 2001. She has been working for the Division of Public Health since September 2001; however, she has been practicing as a nurse for the Commonwealth Health Center since September 1997. Mrs. Camacho also received her advanced education and training from a master's certificate Women's Health Care Program at the University of Texas, Southwestern Medical Program in 2000. She provides women's health services at the satellite public health clinic including the Adolescent Health Center and STD Clinic. Mrs. Camacho participated in the MCH Certificate Program from the University of Hawaii.

Public Health Program Analyst: Ms. Roxanne Diaz received her Bachelor's Degree of Science in Biology from Chaminade University, Honolulu, Hawaii. Her primary function is to monitor all federally and locally funded programs, correspond with the local academic community, explore and identify various education, training, funding, and/or technical assistance available that may be beneficial to the Department. She completed the MCH Certificate Program from the University of Hawaii in 2008.

MCH Coordinator: The MCH Coordinator is Mrs. Margarita Torres-Aldan. Mrs. Torres-Aldan holds a Master's Degree in Public Health (Health Service Administration) from the University of Hawaii and A Bachelor of Science Degree from the University of Colorado, Denver. She has experience in the field of social work, including interagency liaisons, adolescent health, and services for children with special health care needs.

Arielle Buyum, MPH, CPH, is the CNMI Family Planning Program Manager. She received her master's degree in public health from the Rollins School of Public Health at Emory University and is also a bachelor prepared registered nurse. She currently implements the Title X family planning services grant, coordinates adult and adolescent reproductive health services, and directs the family planning/HIV integration special project.

Community Health Nurse: Ms. Dianne Francisco is the Adolescent Health Center Coordinator at the Marianas High School. She is a registered nurse who received her degree from Northern Marianas College. Ms. Francisco provides health services to the adolescent population, primarily in the field reproductive care. Her duties include family planning counseling and services and sexually transmitted disease education, prevention, and testing.

Public Health Registered Dietitian: Ms. Louise Oakley received her Bachelor of Human Ecology Degree with a major in foods and nutrition from the University of Manitoba; Winnipeg, Manitoba,

Canada. She completed a one year dietetic internship at the Health Sciences Centre in Winnipeg, Manitoba. Ms. Oakley is licensed with the College of Dietitians of Manitoba and holds a professional membership with Dietitians of Canada. She works closely with the Diabetes Prevention and Control Program and provides nutrition counseling on an outpatient basis to clients of all ages with varying nutritional disorders.

Epidemiologist: Mr. Edward Diaz, graduated with a Masters of Public Health Degree in Epidemiology from the University of Hawaii. He joined the Division staff in May 1998. Some of his professional interests include disease intervention programs, data collection, disease reporting, and health information system, communicable and non-communicable disease surveillance and outbreak investigation. He currently is the director for the communicable disease program.

Statistician IV: Mr. Isidro Ogarto joined the Division in April of 2003. He brings his statistics experience with him working at the Department of Commerce, Central Statistics Division.

State System Development Initiative Project Coordinator: Ms. TaAnn Kabua recently joined the Division of Public Health in April. She has an Associate's Degree in Liberal Arts from Leeward Community College. In collaboration with the Office of Health and Vital Statistics and other programs required to report data, she participates in the development, integration and implementation of comprehensive supporting IT infrastructure to include data sharing systems, data linkage, web-based e-government systems and the Division of Public Health Administration wide internet access.

Accountant IV: Ms. Frances Pangelinan has been with the Division for the past 15 years. She has extensive experience in banking and financial management. She currently manages all federal and local accounts.

Immunization Program Manager: Ms. Mariana Sablan has been with the VFC Immunization Program since 1995. Ms. Sablan is also responsible for the coordination and collaboration with the Rota and Tinian Health Centers, public and private schools, as well as private health clinics on administering vaccines and following immunization standards and protocols. She oversees Southern Community Wellness Center.

Breast and Cervical Screening Program Manager: Ms. Jocelyn Songsong has been with the Division of Public Health since August 1998, and currently manages the Breast and Cervical Screening Program. She received her associate degree in Liberal Arts at the Northern Marianas College in 1995 and has attended various professional education trainings.

Diabetes Control and Prevention Program Manager: Ms. Tayna Belyeu-Camacho is the Program Manager. She received her AA degree from Northern Marianas College. She has attended trainings in diabetes patient education and coalition building.

HIV/STD Program Manager: John Dax Moreno is the Communicable Disease Manager for the CNMI DPH HIV/STD Resource & Treatment Center. He implements the CDC's HIV Prevention Projects in the Pacific, Comprehensive STD Prevention Project and Infertility Prevention Project, HIV/AIDS Surveillance, and HRSA's Ryan White CARE Act Part B that provides treatment and Core Services for People Living with HIV/AIDS. He has an Assosciates Degree in Nursing Science from The Northern Marianas College.

We also have contractual services of Angie Mister, AuD, that provides program oversight and audiological services for our newborn screening program and Mr. Quan Shengsong is our contractor for the EHDI surveillance system, newborn metabolic screening database and the birth defects database. Both have been instrumental in the linkage of our programs with the birth certificate database.

Administrative staff provides support in clerical, procurement of supplies, inventory control, processing of travel papers, and time and attendance. The Health and Vital Statistics Office is responsible for processing birth and death certificates in addition to data collection for the Division. Our dental assistants and dental hygienists continue with the Head Start and School Program. They expand their service to home visits and have formed partnership with other programs such as WIC to provide fluoride varnish application at their clinic.

Our staff that provides service coordination for children with special health care needs is a parent of a child with special health needs. She has a nursing background and is multi-lingual. She has been instrumental in bringing in parents to participate and facilitates parent events. We have found that parent involvement for CSHCN has increased since we have been working with the different groups. For example, there are 4 parents that have submitted their interest to join the Interagency Coordinating Council for the Early Intervention Services Program even though we have 1 year remaining for membership re-appointment. We have an active support group for our parents that have children that are deaf and hard of hearing. They have implemented every other week Sign Night, have facilitated and coordinated the annual parents retreat, and provided information on our revised written materials. There is an active Autism Society in which one of our pediatrician is a member. The MCH through the Big Steps for Little Feet Project has increased awareness of autism through print media. Parents/grandparents ranked first as the main referral source to our CSHCN or EIS Program. We also have on staff care coordinators for our early intervention services program and a social worker that assists families with needs such as transportation and access to services such as Medicaid, private dental and health clinics, WIC Program, and Nutrition Assistance Program. We work with clinical staff and health care providers for referrals and provide training and educational materials on growth and development to them. Lastly, we have to mention our work with our partners to assist us with our mission to provide the community with the tools and knowledge to live healthier lifestyles such as the student nurses volunteers. We have also provided incentives to increase involvement such as with translation

We want to also mention the contractor that have been instrumental in the implementation of the EHDI surveillance system and newborn screening database and the audiologist for the newborn hearing screening program. The procurement of contractors/consultants have assisted us to improve our data collection and service delivery.

E. State Agency Coordination

The Commonwealth of the Northern Mariana Islands (CNMI) government is the provider of all state health and human services. Each state agency is under the supervision of the governor and is headed by a single executive. This include the Public School System, Department of Community and Cultural Affairs, CNMI Developmental Disabilities Council, Office of Vocational Rehabilitation, Nutrition Assistance Program, etc. Most of our work with other state agencies is through a Memorandum of Understanding/Agreement (i.e., Public School System) or serving as a member of a council or committee. As was mentioned in the organizational structure section, public health, mental health including alcohol and substance abuse, Medicaid and SCHIP, and hospital services are provided by the Department of Public Health. There is only one government operated hospital in the CNMI -- the Commonwealth Health Center; Rota and Tinian have mini health centers. The Commonwealth Health Center (CHC) serves as the central acute care facility in the CNMI. Patients from Rota and Tinian are referred to CHC.

The Department's collaboration and partnership with other agencies, both public and private, is important to ensure the continuity of the delivery of services to the people of the CNMI. As has always been mentioned, the strength of the Program is in its work with partners that are committed and dedicated. Collaborative efforts in prevention and educational outreach activities among the programs within the Department are necessary to enhance the capacity of the MCH Program. This is one of the most critical components in the organizational relationships within the

Division. As was mentioned in the Other (MCH) Capacity section, the staffing for the Health Education and Promotion involves all community outreach workers from all the programs. With the reduction in our budget this is one way to ensure that we are sharing and maximizing our limited resources.

Collaboration and partnership among the different programs within the Division of Public Health:

- Funding for HIV prevention and STD prevention comes from the Centers for Disease Control (CDC). Collaborative activities include: 1) Training to clinical staff to provide pre and post counseling for HIV to pregnant women 2) Counseling and testing for STD, including HIV, amongst the young adult population at Southern Community Wellness Center and the Adolescent Health Center and HIV/STD Resource Center. 3) Outreach activities during community events and awareness events are also shared.
- The NCD Prevention Integrating Diabetes & Tobacco is funding from the Centers for Disease Control that supports the Diabetes Prevention and Control Program. Collaborative activities include: 1) Counseling, written materials and supplies for the glucometer loaner program to pregnant women with gestational diabetes. 2) Assisting with case management of those with gestational diabetes. 3) Provide intervention measures at the elementary school level, including Rota and Tinian.
- CDC also provides funding for the Breast and Cervical Cancer Screening Program. This funding opportunity has expanded our capacity to provide pap test and mammography services to low-income women. Collaborative activities include: 1) The MCH Program Coordinator was one of the staff that wrote the grant application. 2) Conduct public awareness activities for our women on "Early Detection is the Best Prevention". 3) Referral source for women to the program. 4) Conduct outreach activities each year during Women's Health Week. 5) Eligibility assistance to Medicaid and the Medically Indigent Assistance Program.
- The Immunization and Vaccines for Children Program also receives funding from CDC. Collaborative work include: 1) Public awareness on age appropriate immunization; provide community with Medicaid information and private health clinics that accept Medicaid. 2) Assist with staffing during mass immunization campaigns. 3) Tracking and referral for immunization, hearing screening, dental care, etc. 4) Home Visits
- Family Planning Program is funded by Office of Population Affairs. Collaborative activities include: 1) Adolescent Health Center - supplies, educational materials, referrals, etc. 2) Prenatal Care -- media campaigns, implement Prenatal Care Village Project. 3) Conduct outreach activities each year during Women's Health Week.
- Wise Women Village Project - Through a collaborative partnership with our Maternal Child Health Program, we have coordinated an educational class for pregnant women with gestational diabetes and preexisting diabetes to provide education regarding diabetes prevention and management, healthy lifestyle practices, nutrition, physical activity, and preventive health issues. We also informed the private health clinics of the class for referral. Lastly, MCH has been a partner in the outreach to the villages to provide women's health screenings and education and counseling.
- WIC Program (USDA funding source) -- 1) Referral source for the program. 2) Breastfeeding -- partnered for the certified lactation counseling training; Contractual services of a masters level nurse to work with nursing staff to increase breastfeeding rates; and working reinstate "Baby Friendly" facility. 3) Fluoride varnish application project -- dental assistants provide this service at the WIC Clinic once a week.
- CDC Public Health Emergency Preparedness -- developed plans for public health emergency such as pandemic, natural or manmade disasters, public education awareness (H1N1), and provides public health program with support for information pertaining to their target population.
- Local funds support salaries for clinical staff including registered nurses and nursing assistant, mid-level providers, physicians, administrative support, epidemiology, and data support.

Community Guidance Center (CGC): Staff from the Community Guidance Center provides substance abuse counseling and education on-site at the Adolescent Health Center. We also

collaborate in conducting outreach presentations such as betel nut chewing. CGC is the referral site for pregnant women that want to stop smoking. It also provides the satellite clinics with educational materials.

- The Tobacco Prevention and Control Program conduct public education on tobacco prevention through radio announcements, community events and school activities. We assist with the sting operation to ensure that stores do not sell tobacco products to minors. We refer our clients to their tobacco cessation program.
- Substance Abuse Prevention and Treatment Program
- Project Brabu - MCH works with the center on their newly funded HRSA project addressing underage drinking.

Hospital Division: The Medical Referral Program at the Hospital Division sends those children with special health care needs off-island for medical care not available on island. The Program facilitates the referral of clients to recognized referral health care facilities outside the CNMI. It provides financial assistance for medical care and other related costs (i.e., lodging). The OB/GYN unit provides care for high-risk pregnant women. We are also coordinating our work in the Prenatal Care Village Project.

Medicaid Program: Coordinate eligibility assistance for clients coming to the wellness centers. The Social Worker is stationed at the Medicaid Office once a week to assist our families with special health care needs with processing of application. We have increased public awareness of Medicaid Program by including the program's information on all our print ads. We also include information on the four private health and dental clinics that accepts Medicaid.

Infrastructure building for the CNMI includes training, improving systems of care, and strengthening our information system. Because we are a manpower shortage area, we partner with National Health Service Corp to recruit physicians and dentists. We work with universities in the mainland such as University of Virginia in which MPH students come to the CNMI and work on projects such as Childhood Obesity.

Funds have been used for training of care coordinators, nurses, staff from the Health and Vital Statistics, administrative support staff in the areas of computer, outreach program, nursing home care, telemedicine, etc. It has been instrumental in our work to improve not only data collection for the MCH Program but for the Division of Public Health. Funds were also used to purchase computer equipment for the different units and other programs to ensure data collection. The State System Development Initiative Grant has benefitted all programs in their capacity to collect data and evaluate components or activities of the program.

The Division of Public Health's collaboration with other Departments and/or Agencies:
Public School System:

- Early Intervention Services Program - Since the inception of the program in 1986, the Public School System has been the lead agency. Through an MOU, early intervention services are provided to children and families 0-3 years of age. The program is housed at the Children's Developmental Assistance Center (C*DAC) and public health is responsible for maintenance of the facility and for providing public awareness and child find activities. The salaries for Care Coordinators and the Social Worker is supported by the Department of Public Health while the Public School System employs the related services providers including special education teachers, speech therapy, occupational therapy, etc.
- Newborn Hearing Screening Program - This has been one of the "best practices" for coordination and collaboration. Newborn screening has been conducted since 2002. The EHDI surveillance system was implemented in 2007. The audiologist provides programmatic oversight of the program in addition to conducting diagnostic screening. We have been screening 98% of infants before hospital discharge. We have also reduced our lost to follow-up from 47% to 4%.
- Oral Health - The provision of transportation of 1st, 5th and 6th grade students by the Public School System has been the key factor for the success of the school health program fluoride varnish and sealant.applications component.

- Head Start Program -- we provide sealant application at each of the Head Start center. We also schedule appointments for Medicaid enrolled students needing restorative treatment. In addition dental assistants conduct home visits with family advocates to talk about good oral health. Finally, one of our best collaboration is our annual "Week of the Young Child" in which we conduct activities for families and children on health, literacy, parenting, and family support.

Northern Marianas College (NMC):
As was mentioned in the State Overview narrative section, one of the Division of Public Health's initiatives is building local staff capacity. The Department coordinates with the college training in the area of nursing and allied health area; partners with the Cooperative Research Education Extension Services Program in nutritional education activities such as cooking demonstrations; and coordinates with the School of Nursing volunteers for our community events such as health fairs.

Department of Community and Cultural Affairs (DCCA):
- Child Care Program: coordinate our work for annual health and safety training for child care providers; Child Care Program is our other partner together with Head Start for the annual "Week of the Young Child" in which we conduct activities for families and children on health, literacy, parenting, and family support.
- Training on parenting skills is provided by DCCA Division of Youth Services staff. When requested public health provides counseling and conduct health presentations to the youths at the Juvenile Detention facility.

Department of Commerce -- we work closely with the Central Statistics Unit in the area of data collection and population estimates. Last year we signed a MOU to conduct the BRFSS survey. The results are currently in a draft form and we will use the data for next year's grant submission.

University of Hawaii, John A. Burns School of Medicine --
- Maternal and Child Health Certificate Program -- The Public Health Analyst completed the program in 2008.
- Healthy Living in the Pacific Islands survey was conducted to help determine some of the health needs of the islands' children.

Developmental Disabilities Council:
The MCH program staff has served as a member of the council since 2002. We have assisted with grant writing, focus groups, and panel presentations. We refer clients to their Assistive Technology Program. We refer families with disabilities to the Family Hope Center.

Ayuda Network: This is a non-profit agency that MCH collaborates with to create the resource directory for our clients. They assist in community events by manning exhibits, hosting meetings, and partner in bringing trainers on island.

Private Health Clinics: As was mentioned earlier, our most successful collaboration with all the private clinics is with the Immunization Program. During awareness events, i.e., public health awareness week, women's health week, and breast and cervical cancer prevention awareness month, we have collaborated with two private clinics in providing pap smears to our indigent population. We have also collaborated with private dental clinics to in our outreach activities.

CHC Volunteers Association: They have assisted us with purchase of supplies for our hearing screening program and for our Prenatal Care Village Project.

Secretariat of the Pacific Community (SPC): SPC provides training, manages the pacific public health surveillance network, and provides health alerts. We also received a grant to develop a strategic plan addressing all non communicable diseases (NCD) and to link all with other NCD programs. We also were provided training to conduct NCD survey specific to the CNMI.

PIHOA: Provide technical assistance in grant writing, training, etc.

To reiterate, MCH supports and participates with coordination of activities with internal and external partners focusing on MCH population groups. In addition, we are referral source to activities in the community - for example we are providing information to everyone coming to our clinics or community events of the upcoming seminar at our public library focusing on self management tools for healthy living.

F. Health Systems Capacity Indicators

Introduction

The MCH Program works closely with its partners to ensure that it conducts activities that will influence the program's ability to maintain or improve the following health systems capacity indicators. Now that there are private clinics providing services to Medicaid enrollees, we provide them with materials that are given at public health clinics. The Division of Public Health and MCH Program has established partnerships with agencies in the CNMI providing services to MCH population groups and thus it has access to policy and program relevant information and data. We applied to implement home visiting program which will enhanced and expand our capacity to improve outcomes with our families.

The Medicaid Program has acquired the hardware and database software to link Medicaid and Health and Vital Statistics office databases. The program will be utilizing a front-end database management system called Visual Fox Pro which supports SQL query and data manipulation. The software developer is currently finalizing the networking and providing training for Medicaid staff. TheSSDI Project Director along with the Commonwealth Health Center Systems Administrator will work with Medicaid's system developer to install Citrix application delivery software which will provide an information gateway for MCH to retrie

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	184.7	198.7	83.5	296.9	168.6
Numerator	106	110	47	167	94
Denominator	5738	5536	5627	5624	5576
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

94 children aged 0-4 yrs were hospitalized for asthma.

Notes - 2008

In 2008, 167 children 0-4yrs diagnosed with Asthma were hospitalized.

Notes - 2007

47 children aged 0-4 hospitalized for asthma. Denominator was revised to 5627.

Narrative:

The Department of Public Health does not have a formal program that addresses childhood asthma. However, with the lead of PH Medical Director and MCH staff, we have support of health care providers in that they provide us with key information to provide to parents of children that have asthma such as list of allergens, smoking and asthma, and understanding the importance of medication in both audio and visual format. We have heard from providers that parents are saying the heat is triggering their child's asthma attack. Last summer we provided the four private health clinics with the same educational resources for their Medicaid patients. Medicaid enrollees' ability to access health care at private clinics may be attributed to the drop in numbers. One of the complaints at public health facilities is the long waiting time. Through our needs assessment work we heard that they don't have to wait long at private clinics. We have also worked with the Gift Shop located at the hospital to sell the nebulizer machine that can be purchased by Medicaid participants.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	24.4	37.0	43.3	32.5	95.7
Numerator	325	526	438	267	265
Denominator	1332	1422	1012	821	277
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Notes - 2009
265 received at least initial periodic screen within 6 wks immunization.

Notes - 2008
In 2008, 267 <1yr medicaid enrollees received at least one initial periodic screen at 6 six immunization screening. Enrollees pending immunization.

Notes - 2007
1012 medicaid enrollees less than 1 year old in 2007; 438 under medicaid had initial screen. Need to finalize figure.

Narrative:
Through the Early Childhood Comprehensive System Project we have increased our awareness campaign on growth and development; well child visits; oral health; immunization; developmental screening to name a few. We have increased our capacity to improve or increase this indicator since Medicaid enrollees can access health screenings in the private health and dental clinics. We provide care coordination for CSHCN including those enrolled in the early intervention services program. Please note that immunization is provided on-site at the Children's Developmental Assistance Center (we did the same for seasonal flu and H1N1 vaccines). Immunization is also provided at four private health clinics. We conduct free developmental screening through the EIS Program at WIC and Immunization Clinics and open the Center one Saturday a month.
We provide Medicaid Program information; provide eligibility assistance; and place brochures on

preventive health screenings at the Medicaid Program Office. Our inability to access data such as this from the private health and dental clinics may contribute to our decrease (although not significant). Since 2008 Medicaid enrollees can access health care at 4 private clinics.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	24.4	46.6	43.3	32.5	95.7
Numerator	325	526	438	267	265
Denominator	1332	1129	1012	821	277
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Same as Medicaid. Actual figure pending immunization.

Notes - 2008
Same as Medicaid. Actual figure pending immunization.

Notes - 2007
SCHIP same as medicaid.

Narrative:
Please note that SCHIP is implemented as an expansion of Medicaid thus this would be the same at Health Systems Capaicty Indicator #02.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	24.2	32.8	43.5	18.8	18.0
Numerator	323	466	515	22	34
Denominator	1332	1422	1183	117	189
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
The data reported is from a face-to-face interview with 135 patients after delivery.

Notes - 2007
Beginning with the 2007 annual report, the Pacific Basin Jurisdictions may have changed to the World Health Organization (WHO) standard rather than the Kotelchuck Index to report indicator data for HSCI04. The WHO standard recommends as essential that pregnant women make four prenatal care visits.

1183 qualified pregnant women to determine kotelchuck index. 515 had adequate prenatal care checkup.

Narrative:
Because Medicaid enrollees can access prenatal care at 4 private health clinics we have been including this information in our prenatal care ad campaigns. We have increased our work with Medicaid Program by processing applications of pregnant women referred especially by the physicians. Most of the women that participated in the postpartum survey evaluating prenatal care visits only wanted Medicaid so that it can cover the health care costs of their infants. They did not know that it covers prenatal care costs also. Therefore, information that Medicaid covers all prenatal care costs including doctor's visit, lab works, etc is included in our ad campaigns. We still have to work out the appointment system -- when women call and the appointment schedule is full for that month they are told to call back the first week of the following month because the doctor's schedule for next month is not available. Per Dr. Grant -- she has informed clinical attendants to go ahead and make the appointment since there are always providers at the clinic on a daily basis.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	26.1	32.6	27.4	29.2	34.1
Numerator	6313	7261	6113	6550	7685
Denominator	24150	22248	22319	22409	22527
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
7685 received service paid by medicaid program aged 1-21 yrs

Notes - 2008
In 2008, 6550 1-21yrs old received service paid by Medicaid program.

Notes - 2007
6,113 children 1-21 yrs received service paid by Medicaid Program. Data derived from RPMS. Denominator revised from 25466 to 22319.

Narrative:
One of our strength in this area is that we have staff that can provide eligibility assistance to our families at seeking services at public health clinics. We are continually referring famlies to Medicaid Program as well as to the Medically Indigent Assistance Program. Because Medicaid can pay 3 months retroactive for services we assess the families income and provide the services with the referral process to Medicaid. Please note that publi health clinics provide services to residents of the CNMI regardless of insurance status or ability to pay. When patients inform us that they have submitted Medicaid applications or are waiting for their Medicaid Card, we do put write this down as part of their patient information on the insurance section. As has been mention the CSHCN Social Worker continues to go with families as requested to the Medicaid Program Office for appointments and is stationed once a week at the Office. Private clinics do not see the uninsured so they would come to public health clinics. Also private health clinics do not provide eligiblity assistance (we tried to include them in the training but due to staff limitations they were unable to come).

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	23.9	24.9	27.8	22.8	19.3
Numerator	1267	1035	1165	967	827
Denominator	5307	4164	4186	4238	4291
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
In 2009, 827 medicaid enrollees received dental services.

Notes - 2008
In 2008, 967 medicaid enrollees received dental services.

Notes - 2007
1,165 children 6-9 years received dental services in 2007. Data derived from RPMS. Denominator revised from 5671 to 4186.

Narrative:
We have initiated discussions with private dental clinics regarding providing public health with this data. There is only 1 dentist at the public health dental clinic thus we have increased our referral to the private dental clinics. We provide sealant and fluoride varnish service through our school dental program every school year. We have implemented the restorative treatment service for Head Start students and again because of shortage of dentist at public health dental clinic we schedule appointments with private dental clinics and provide parents with information. We do follow-up call for only those students scheduled for services at PH dental clinic. Finally, we have increased awareness on children's oral health in collaboration with ECCS. Educational resources are also provided to private dental clinics.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	45.4	89.7	88.0	87.4	94.9
Numerator	147	209	221	236	282
Denominator	324	233	251	270	297
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Notes - 2009
282 <16yrs old SSI beneficiaries received services.

Notes - 2008
239 <16yrs old SSI beneficiaries received services.

Notes - 2007
Children 16 and less receiving SSI

Narrative:
We are fortunate with our collaboration with the Public School System (PSS) to provide rehabilitative services including physical, occupational, and speech therapy. In addition, they accompany children to specialty clinics visits such as Shriners. MCH supports training and care coordination for CSHCN/EIS programs. Within the CNMI respite services are almost non-existent; families that have the financial means would hire non-resident workers to assist them in the care of their children. Medicaid does cover cost for rehabilitative services.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2009	matching data files	28.3	71.7	4.8

Narrative:
As has been mentioned, MCH Program and other DPH programs does place informational and educational materials at the Medicaid Program Office. Also, all written materials provided at public health clinics are also provided to private clinics seeing Medicaid enrollees. When we have our in-service during community partners training and panel presentations for CSHCN, we do include data on Medicaid like how many Medicaid children are up-to-date with their

immunization. We make reports on Medicaid population available to the Program. We continue to conduct health and wellness presentations to Head Start famlies . In collaboration with ECCS and other partners we have increased our awareness activities. The revision of the birth certificate to the 2003 standard form will hopefully improve the reporting and recording of this health system capacity indicator.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2009	matching data files	5.1	5.1	10.2

Notes - 2011
There were only 2 infant death in the CNMI for 2009.

Narrative:
Being that the Office of Health and Vital Statistics have stand alone death certificate database we can easily access this information. In the database it has a column for insurance status which again is a benefit to us in our work to collect this information. We continue to put our work into educating the community to importance of prenatal care visits, immunization, well baby care visits etc. We provide training to clinical staff and again we provide educational materials to public health clinics, private clinics, Medicaid Program Office, and other service providers.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	matching data files	37.7	62.3	28.5

Notes - 2011
316 pregnant women had prenatal care during the first trimester.

Narrative:
We continue to include Medicaid Program's information on all prenatal care ad campaign. There are 4 private clinics that provide prenatal care services to Medicaid enrollees. Some of our awareness activities include billboards, educational materials, and focus groups. If we call Medicaid office to refer pregnant women they will process the application in a timely manner.

One of the OB/GYN has been contacting Medicaid Office on a regular basis to refer pregnant women. Again, if a pregnant woman does qualify for Medicaid then the Program will pay 3 months back for services she has received. We continue to refer low-risk prenatal patients to the private clinics. We are still working to improve the scheduling of prenatal appointments at the Women's Clinic. One of the state priority need is to ensure early entrance into prenatal care for pregnant women enrolled in Medicaid Program.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2009	other	0	0	0

Notes - 2011
The source is not available at the time of submission until next month. The data has been prepared but could not obtain. The data will be available at the hearing.

Narrative:
We will report last year's kotelchuck numbers as the numbers for 2009 is not completed yet. We continue to struggle with missing and incomplete data. When Office of Health and Vital Statistics were working to revise the birth certificate form to the 2003 standard form they worked with the OB/GYN unit to review information on the form and to provide comments which they did. The challenge is to continue to work with them for proper reporting/recording of information.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	218
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	218

Notes - 2011
estimated number of infants derived from RPMS

Notes - 2011
same as medicaid data. data derived from RPMS

Narrative:
Per instructions on page 150 it states for #06a, enter the percentages of poverty level required for Medicaid and SCHIP program eligibility for all infnants 0-1 in the state. This would be 150 percent of poverty for this target group. Medicaid Program follow the poverty guideline for state of Alaska. We continue to increase our referral to Medicaid Program.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 4) (Age range 5 to 9) (Age range 10 to 19)	2009	 150 150 150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 4) (Age range 5 to 9) (Age range 10 to 19)	2009	 150 150 150

Notes - 2011
Will verify with medicaid program for % of poverty level

Notes - 2011
Will get verification from medicaid program

Narrative:
The percent of poverty level required for program eligibility in the State's Medicaid and SCHIP program for infants, children, and pregnant women is at 150%. Eligibility assistance is provided at public health clinics including CSHCN. Again, public health staff including health care providers are actively referring to the Program.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	150

Notes - 2011
Medicaid program data incomplete for pregnant enrollees.

Narrative:
The percent of poverty level required for program eligibility in the State's Medicaid and SCHIP programs for infants, children, and pregnant women is at 150%. The Program follows Alaska's poverty guidelines.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	2	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	2	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	2	No
Survey of recent mothers at least every two years (like PRAMS)	2	Yes

Notes - 2011

Narrative:
The MCH Program has the ability to obtain data in a timely manner from our partners. The concern here is the quality of the data. We procure the contractual services of the developer of EDHI surveillance system and newborn screening database to develop and implement the birth defects database. One of the concerns in conducting the CSHCN survey is that we do not have a registry to assist us ensure that we will capture all CSHCN. We will be reviewing the reporting accuracy on anomalies on the new birth certificate form. While birth data from vital records are

not linked with Medicaid data, Medicaid information is now available on the newly revised 2003 birth certificate standard form.
Annual linkage of infant birth and infant death certificates: The Health and Vital Statistics Office has a birth and death certificate database separate from RPMS. MCH Program has the ability to obtain data and have direct access to the database.
Annual linkage of birth records and Medicaid eligibility or paid claims files: At present, the software developer is finalizing the networking and providing staff training on entry and management of new data system. The contractor will then develop an information gateway between Medicaid, birth records, and other relevant MCH data sources.
Annual linkage of birth records and WIC eligibility files: The two challenges in our work are: 1) WIC Program is using Arizona's system and 2) USDA's requirements.
Annual linkage of birth records and newborn screening: The newborn screening database was implemented last year. We access and import the newborn screening results directly from the Oregon State Public Health Laboratory on a weekly basis electronically. The database is linked to the birth certificate database.
Hospital discharge survey for at least 90% of in-State discharges: Although there is no direct link to this information, the MCH Program does have access to the information. The Commonwealth Health Center (CHC) recently upgraded modules in RPMS from MSM to Cache. This will allow CHC to progress to electronic medical records.
Annual birth defects surveillance system: We also included in the deliverables for the newborn screening database contractor to develop a birth defects registry.
Survey of recent mothers at least every two years: We did conduct a PRAMS-like survey in which 90 of 150 was completed. We are still working on the report. Also, the OB/GYN conducted a postpartum survey to evaluate prenatal care services in the CNMI.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2011

Narrative:
Smoking data is gathered from the Youth Risk Behavior Survey (YRBS) conducted by the Public School System (PSS) and Youth Tobacco Survey (YTS) conducted by the CNMI Tobacco Prevention and Control Program (TPCP). We have not been able to conduct another YTS since 2004. However, the TPCP is working with WHO on conducting one in September or October of this year. (We have the support of the Commissioner of Education for school year 2010/2011.) In addition, most private schools are willing to participate. We have to work harder with our partners on the enforcement side of selling tobacco products to minors because one of the recurring statement from participants of the adolescent health determinant is "it is easy to access tobacco products". Although the 2009 YRBS has been conducted survey results has been officially released by PSS. There has been a downward trend per YRBS. The percentage of students who ever tried cigarette smoking, even one or two puffs decreased from 87.9 in 2003 to 78.1 in 2007. The percentage of students who used chewing tobacco, snuff, or dip on one or more in of the past 30 days went from 42.5 in 2003 to 36.3 in 2007.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The continual decrease in Department of Public Health's budget has moved the Maternal and Child Health program and other programs at the Division of Public Health to expand its collaborations to other resources. Specific program activities are developed and categorized by the four service levels found in the MCH Pyramid: direct health care services, enabling services, population-based, and infrastructure-building. We allow for flexibility in implementing activities to address emerging priority need such as H1N1.

The provision of direct health care services in the CNMI is provided at public health clinics and at private clinics. We are continually experiencing manpower shortages such as physicians, nurses, nutritionist, and other related services. Therefore, bringing Medicaid out into the private health and dental clinics has allowed MCH Program to increase access to direct health care services to MCH population groups and thus improve our progress towards successful achievement of the performance measures. Services include prenatal care, postpartum care, well child exams, dental care, immunization, pap test, clinical breast exam, audiological testing. In return we get referrals from the private clinics for early intervention services and specialty clinics. Medicaid enrollees can avail to a primary care provider at these clinics.

Last year, we started working with the private clinics on enabling and population-based services. Therefore all educational materials provided at public health facilities are provided to the private clinics also. Early Childhood Comprehensive System is a referral source for families. It assists families beyond referral to Medicaid program and private clinics. These include parenting education or support, food stamp, housing, education, early intervention services, transportation, educational materials, etc. The Project supports enabling and population-based services for youth centers in the villages, Reach Out and Read Program, Motheread/Fatheread, childcare centers, etc.

As programs we are considerate of the financial situation of families. Through our work with village projects we know that if we bring the service to them they will come. This also helps progress in our efforts to reduce health disparities. Immunization is provided at Children's Developmental Assistance Center and at Head Start centers. Fluoride varnish and sealant application is conducted also at Head Start centers, WIC and Immunization clinics. We provide our partners with information such as ‘talking points' for them to avail the opportunity to talk about general preventive health screenings to their target group. In addition, the information is also in our awareness media campaign which includes print, radio spots and tv. Developmental screening is provided free one Saturday a month and also at Immunization clinic as an activity to increase referrals to early intervention services program. Our work with school-based clinics meets the students in their environment thus creating trust with us as service providers in teen pregnancy and STD prevention. We continue providing women's health exam in partnership with Breast and Cervical Screening Program and Wise Women Village Project out in the villages. Because the most prevalent cancers in women in the CNMI are those that could be prevented and/or cured with early detection and treatment, we worked to overcome cultural and financial barriers and educate women on the importance of screening. Access to pap test and mammogram has been identified as priority needs by our women.

Although we have met the objectives on most of the national and state performance measures, we continue to be challenged by low prenatal care rates, high dental caries among Head Start children, lack of data, inability to access data, etc.

In looking at the expenditures and budget for the MCH Program, we continue to use majority of the funds for direct health services. This is a reflection of the decreased in budget for the Department as a whole. Again, the program continues to also work with other programs that can provide direct health services while we focus on the other three service levels of the MCH

pyramid.

B. State Priorities

The priority needs for the CNMI MCH Program focuses on getting the community's input as to what are needs for each specific MCH population groups. MCH Program collaborated with community members such as women's group, parents, pregnant women, parents of CSHCN and internal and external partner to identify state priority needs. We reviewed information such as health status indicators, performance and outcome measures, resources and capabilities for the MCH Program and the Department of Public Health in general. In assessing the capacity the weakness is that the MCH Program worked with internal partners only in identifying strengths, challenges, and opportunities to provide services/activities/initiatives for each need.

SPM#1: The percent of unplanned pregnancies for women aged 15-44 years.
Reducing unplanned pregnancies is possible and necessary. The result of unplanned pregnancy is that the mother is less likely to seek prenatal care during first trimester and less likely to have any prenatal care. The child of such a pregnancy is at greater risk of low birth weight and other complications. Last year 75% of live births were unplanned. Last year a survey was conducted to evaluate access to prenatal care. One hundred thirty-one surveys were obtained. Twenty women gave the reasons for not receiving adequate care is because they were unaware they were pregnant. Pregnancy test kits are available at all public health clinics. With the revision of the birth certificate to the 2003 standard form, we are looking to review birth outcomes and unplanned/planned pregnancies. DPH applied for the ACA Home Visiting Program and we will work with these mothers to ensure that they access preventive health screenings for both themselves and their babies.
We continue to work with the Family Planning (FP) Program for counseling, education, contraceptives, fee waiver for adolescents. We continue to send staff to participate in the Title X Pacific Basin FP conference. Two local nurses are certified women's health nurse practitioners and are providing services at school-based and satellite clinics. This activity is related to NPM#8 and #18 and SPM #7. Activities can also focus to working with mothers for infants screening such as NPM#1; #7; #11; #12; #14 and #15.

SPM #2 Percent of women who ever received a pap test.
In the September 2004 issues of Pacific Health Dialog, a 10 year study (1991-2001) of cancer among women in the CNMI shows that of the 304 cancer 29% were breast cancer and 20% were cervical cancer. Six women are diagnosed with cancer every year in the CNMI. There were 15,543 women aged 25-60 years that were identified as not having had a pap smear for the past 4 years in 2004. The MCH Program partners with the BCCSP (Breast and Cervical Cancer Screening Program) to increase access to pap services and awareness and outreach activities. In 2005 it partners with the Wise Women Pap Project in which women on the list were scheduled to come for free well-women exams during the evenings at the Women's Clinic. As partners we saw the need to implement gender-focused free preventive health screenings, community education, and medical management and so we submitted the ASSIST 2010 grant application with the lead of the nurse midwife to implement Wise Women Village Project (WWVP). We have been collaborating with 2 private clinics to provide this service to these identified women. The target population for the MCH Program is all women whereas the target group for BCSP has to fall within the program's eligibility guidelines and the target group for WWVP is local indigenous women. Therefore, we refer women (especially those with no insurance) that qualify for these programs and MCH provides the support for outreach and awareness activities. In addition, we provide staffing for the two initiatives. We have focused activities for Women's Health Week on going to government agencies to educate women on importance of pap test and provide the services in our mobile clinic. We get assistance on case management for abnormal test results from BCSP. A major intervention activity for WWVP is participant education regarding physical activity, BMI, nutrition, and tobacco cessation counseling. We provide educational materials to private clinics for their Medicaid clients.

These activities are related to NPM#15, #18, and SPM#1, #2, #3 and #6.

SPM#3:Percent of women who have ever received a mammogram.
Of the 304 cases of cancer in females from 1991-2001, 29% were breast cancer. Findings suggest that cancer is the second-leading cause of death in CNMI. Because the most prevalent cancers in women in the CNMI are those that could be prevented and/or cured with early detection and treatment, we must overcome cultural barriers and educate women on the importance of screening and in making sure that they have access to these screenings. Clinical breast exam is one of the preventive health screening provided at the village project and the evening clinic. Women needing mammography services are referred. We have focus activities for Women's Health Week on going to government agencies to educate women on self breast exams and have providers also conduct clinical breast exam. We provide magnets on when to get women's health screenings during this week. The cost of cancer screening tests and the lack of radiologist continue to be significant barriers. We provide educational materials to private clinics for their Medicaid clients.
These activities are related to NPM#15, #18, and SPM #1, #2, and #6.

SPM#4: Percent of eligible infants with disabilities under 1 year receiving early intervention services.
The CNMI provides early intervention services (EIS) to infants and toddlers, birth through age three, and their families in collaboration with the Public School System (lead agency) since 1986. This is the entry point for children identified with special health care needs. Majority of the children being referred to the EIS program is mostly older than 1 year of age. There are 54 children enrolled in the EIS Program in which 1% is under one year of age. The program received 79 referrals last year in which 22 were under the age of 1. 41% of our referral source is from the NICU at the hospital, 29% from the PH facilities, and 10% from parent/family. We will continue with our work to emphasize early identification and early intervention for this target population using interdisciplinary team approach. We continue to provide general health information in the prenatal care packet and Early Intervention Services program packet. We collaborate with Immunization program to put developmental screening information on the new shot record. The CSHCN Coordinator works with EIS Program staff in child find and public awareness activities including Medicaid participating private health clinics. We have increased conducting developmental screenings to one Saturday a month, and at WIC and Immunization Clinics. We also are working with daycare centers. In the 2010 Head Start Community Needs Assessment two priorities are increase numbers of children being identified as having developmental delays or disabilities in early childhood and increase the number of children screened for autism and language and speech disorders.
These activities are related to NPM#1-6, #8, #12, #13, #18 and SPM#1 and #7.

SPM#5:The rate of Chlamydia for adolescents aged 13-17 years.
In the 2007 YRBS survey results show that the percentage of high school students who ever had sexual intercourse was 49.7 and 18.4 for the middle school. The percentage of high school students who used a condom during last sexual intercourse went from 43.1 in 2005 to 40.1 in 2007. The percentage of high school students who had sexual intercourse with 4 or more people during their life was 19.6. At the school-based clinic gonorrhea and chlamydia testing is provided with approximately 10% of tested students coming up positive for chlamydia. Data from the Hospital's lab unit shows that out of 103 tested for chlamydia for this age group 15 were positive. Adolescents can also access testing at other public health clinics including the HIV/STD Resource and Treatment Center. MCH collaborates to provide testing, medications, tracking, outreach activities and presentations at the schools and community events. Condoms are available for free at all the PH clinics. We are also partnering with another public high school that opened a health center and recruited a nurse last school year.
These activities are related to NPM#8, and SPM#1, #2 and #7.

SPM#6:The degree to which State provides nutrition education information to students aged 6 through 11 years.

The CNMI ranked third in the world for prevalence of Type II diabetes. Obesity has been growing at a fast pace in the CNMI. The rates are higher than those of the US mainland, and this is evident when looking at any typical classroom. Head Start data (p. 400) from School Year 07-08 indicated that 14.3% of children are at risk of overweight (85th-95th%), and 17.5% of children are already overweight (>95th %). The percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile was 25.9. In 2005 the Healthy People Living in the Pacific Islands survey was conducted to 420 children 6 months to 10 years old. Using CDC cut off points, 34% of the children in the survey were found to be at risk for overweight. For those aged 5 to 10 years, 68% has no physical activity outside of school. Some of our collaboration includes Cooking Shows/demonstrations, Healthy Snacks Recipe, bottle weaning, and breastfeeding. The nutritionist is the most requested speaker/presenter at the elementary schools. In collaboration with ECCS, we have provided incentives to children to increase physical activity such as jump ropes and Frisbees. We encourage family participation in DPH village exercise/dance classes.
These activities are related to NPM#11 and #14.

SPM#7:Percent of pregnant women who are screened for Chlamydia.
Our main focus is to increase the awareness of early and continuous prenatal care visits which will make sure that all pregnant women come in early for prenatal care and gets screened. STD information is available in the prenatal care booklet. Additional information is included in the prenatal care packet. We collaborate with HIV/STD Prevention Program for training including CTR and for counseling and partner tracking with their STD case worker. We continue collaboration with other programs in providing free STD testing and medications for indigent women of childbearing age and their partner(s). We are working with other programs to recruit one staff to be stationed at Lab Unit to enhance our tracking. STDs brochures are provided to clients and available at all clinics in the CNMI, including private.
These activities are related to NPM#8, #18 and SPM #5.

The following are the new State Performance Measures
Pregnant Women and Infants
Initiation of prenatal care visits during first trimester for pregnant women enrolled in the Medicaid Program.
Related to NPM #18 -- Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

Improved case management of pregnant women identified a "high risks"
Related to NPM # 15 -- Percentage of women who smoke in the last three months of pregnancy

Initiation of breastfeeding at hospital discharge
Related to NPM #11 -- The percent of mothers who breastfeed their infants at 6 months of age

Percent of women who ever received a pap test.
These activities are related to NPM#15, #18, and SPM#1, #2, #3 and #6

Percent of women who have ever received a mammogram
These activities are related to NPM#15, #18, and SPM #1, #2, and #6.

Children and Adolescents
Developmental screening for children 0-5 years

Improve nutritional status and physical activity in children
Related to NPM #14 - Percentage of children aged 2 to 5 years, receiving WIC services with a BMI at or above the 85th percentile

Decrease teen birth of Chamorro teenagers aged 15 through 18 years
Related to NPM #8 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years

Reduce adolescent risk behaviors relating to alcohol and other drug use

Children with Special Health Care Needs

Input infants with a "diagnosis" into the birth defects database with 6 months of diagnosis

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	82	96.5	97	98.5	98.5
Annual Indicator	96.1	0.0	0.0	0.1	100.0
Numerator	1280	0	0	1	2
Denominator	1332	1422	1385	1266	2
Data Source				Lab	Lab
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.				Yes	Yes
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
There were 2 positive metabolic screening for GALT and Hemoglobin, both received treatment. Need to verify kind of treatment.

Notes - 2008
In 2008, newborn metabolic screening 1112. Hypothyroidism 1 positive case receiving treatment.

Notes - 2007
Metabolic screening 1075. There were no positve case for newborn condition in 2007.

a. Last Year's Accomplishments
1) Newborn Metabollic Screening database completed.
2) Assigned one staff to collect information on babies needing rescreen on a weekly basis.
3) Discussions with pediatricians include reviewing/revising current protocol and to make sure they get a copy of the list of babies needing rescreening.
4) Continue with providing parents with newborn screening brochure.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Development of a database linking newborn screening records with birth certificate database.		X	X	X
2. Monthly review to ensure rescreening		X	X	
3. Newborn screening brochures included in prenatal care packet		X	X	
4. Partnership with Oregon State Public Health Laboratory			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) Reviewing reports to see if additional reports/queries needs to be created
2) Modify database and linkage program so that it works with new birth certificate format
3) Redesign importing program to make it compatible with new Oregon Lab web service
4) Providing Children's Clinic with list of babies needed rescreening

c. Plan for the Coming Year

1) Newborn screening protocols revised (if needed)
2) Increase public awareness on importance of newborn screening
3) Continue to work with Oregon Public Health Laboratory to ensure timely reporting of positive results

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**1109**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	1004	90.5	0	0	0	
Congenital Hypothyroidism (Classical)	1004	90.5	0	0	0	
Galactosemia (Classical)	1004	90.5	0	0	0	
Sickle Cell	1004	90.5	0	0	0	

Disease						
Biotinidase Deficiency	1004	90.5	0	0	0	
Cystic Fibrosis	1004	90.5	1	0	0	
Amino Acids	1004	90.5	3	0	0	
Acylcarnitine	1004	90.5	1	0	0	
Hearing Screening	1096	98.8	7	4	2	50.0
Hemoglobin	1004	90.5	0	0	0	
Adrenal Hyperplasia	1004	90.5	0	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	87	87	87	88	88
Annual Indicator	87.0	87.0	87.0	87.0	59.0
Numerator	147	147	147	147	79
Denominator	169	169	169	169	134
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	88	88	88.1	88.1	88.1

Notes - 2009
CSHN Survey 2009
175 were respondents
134 were qualified

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2005 for this performance measure.

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
1) Collaborated with the school system to assist with the CSHCN survey
2) Medicaid participants can now access health and dental care at 4 private clinics
3) Coordinated training with other service providers to encourage and empower parents/families to work with their children's providers -- provided tips on working with your child's health care

provider

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Reviewed and revised CSHCN survey questionnaire from 2005		X	X	
2. Printed survey		X	X	
3. Conducted training for interviewers		X	X	X
4. Meetings with Public School System Special Education Program and Head Start Program to seek assistance to conduct survey		X	X	X
5. Public Service Announcement about survey being conducted		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) In our efforts to increase our collaboration with private providers we invite them to participate in our trainings and allow for their staff to assist during specialty clinics
2) Continue to review other program's family survey such as the EHDI and EIS Programs
3) Continue to provide transportation and interpreters during specialty clinics
4) Continue to conduct CSHCN survey

c. Plan for the Coming Year

The major activity is to complete the survey and analyze survey data using EpiInfo. We will do public service announcements on components of the survey results and provide copies to our partners and families. We will also work on activities for each performance measure pending survey results.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	68	69	69	69	70
Annual Indicator	68.0	68.0	68.0	68.0	26.9
Numerator	115	115	115	115	36
Denominator	169	169	169	169	134
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	70	70	70.2	70.2

Notes - 2009
53 within medical home. 36 received coordinated, ongoing, comprehensive care.

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2005 for this performance measure.

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
1) Collaborated with the school system to assist with the CSHCN survey
2) Medicaid participants can now access health and dental care at 4 private clinics
3) Staff keep on file information on health care facilities in Hawaii, mainland, Guam and Philippines that is provided to families if they need to be sent off-island for additional care/treatment.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Reviewed and revised CSHCN survey questionnaire from 2005		X	X	
2. Printed survey		X	X	
3. Conducted training for interviewers		X	X	X
4. Meetings with Public School System Special Education Program and Head Start Program to seek assistance to conduct survey		X	X	X
5. Public Service Announcement about survey being conducted		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1) In our efforts to increase our collaboration with private providers we invite them to have their staff assist during specialty clinics for their patients
2) Continue to conduct CSHNC survey
3) Service coordination is provided at Early Intervention Services Program in collaboration with PSS Special Education Program
4) Continue to work with Medical Referral Program for off-island care

c. Plan for the Coming Year

The major activity is to complete the survey and analyze survey data using EpiInfo. We will do public service announcements on components of the survey results and provide copies to our partners and families. We will also work on activities for each performance measure pending survey results.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	68	69	69	70	70
Annual Indicator	68.6	68.6	68.6	68.6	59.0
Numerator	116	116	116	116	79
Denominator	169	169	169	169	134
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	70	70	70.5	70.5

Notes - 2009
134 respondents
112 were qualified
79 have adequate insurance to pay services they need

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2005 for this performance measure.

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
1) Collaborated with the school system to assist with the CSHCN survey
2) Medicaid participants can now access health and dental care at 4 private clinics
3) Medicaid Program information included in all public awareness materials

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Reviewed and revised CSHCN survey questionnaire from 2005		X	X	

2. Printed survey		X	X	
3. Conducted training for interviewers		X	X	X
4. Meetings with Public School System Special Education Program and Head Start Program to seek assistance to conduct survey		X	X	X
5. Public Service Announcement about survey being conducted		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) Continue to conduct CSHCN Survey
2) Service Coordinators and Social Worker provide eligibility assistance to families at the EIS Program
3) Social Worker is stationed at the Medicaid Program every Wednesday to assist with the processing of new and renewal applications for CSHCN and other MCH clients
4) Continue with referrals to Medically Indigent Assistance Program
5) Continue to provide interpreters and transportation when requested to the Medicaid Program Office

c. Plan for the Coming Year

The major activity is to complete the survey and analyze survey data using EpiInfo. We will do public service announcements on components of the survey results and provide copies to our partners and families. We will also work on activities for each performance measure pending survey results.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	44	45	45	46	46
Annual Indicator	43.2	43.2	43.2	43.2	52.2
Numerator	73	73	73	73	70
Denominator	169	169	169	169	134
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	46	46	46.1	46.2	46.2

Notes - 2009
134 respondents
50 reported community based service are organized

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2005 for this performance measure.

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
1) Collaborated with the school system to assist with the CSHCN survey
2) Medicaid participants can now access health and dental care at 4 private clinics

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Reviewed and revised CSHCN survey questionnaire from 2005		X	X	
2. Printed survey		X	X	
3. Conducted training for interviewers		X	X	X
4. Meetings with Public School System Special Education Program and Head Start Program to seek assistance to conduct survey		X	X	X
5. Public Service Announcement about survey being conducted		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1) Participate in agency trainings to increase knowledge of resources available in the community for our clients
2) Continue to conduct CSHCN Survey
3) Resource directory available to parents and is available at health clinics, schools, other agencies, etc. ECCS develops calendars with agencies information and scheduled events for the year which are given to parents.
4) Assist families with referrals to other programs
5) Review other program's family surveys regarding services they receive from them

c. Plan for the Coming Year
The major activity is to complete the survey and analyze survey data using EpiInfo. We will do public service announcements on components of the survey results and provide copies to our partners and families. We will also work on activities for each performance measure pending survey results.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	7	7	8
Annual Indicator	5.9	5.9	5.9	5.9	6.7
Numerator	10	10	10	10	9
Denominator	169	169	169	169	134
Data Source				CSHCN survey	CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8	8	8	8.1	8.1

Notes - 2009
131 respondents
9 received services to make transitions to aspects of adult life

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2005 for this performance measure.

Notes - 2007
The data reported in 2007 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
1) Collaborated with the school system to conduct CSHCN Survey.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Reviewed and revised CSHCN survey questionnaire from 2005		X	X	
2. Printed survey		X	X	
3. Conducted training for interviewers		X	X	X
4. Meetings with Public School System Special Education Program and Head Start Program to seek assistance to conduct survey		X	X	X
5. Public Service Announcement about survey being conducted		X	X	
6.				
7.				
8.				
9.				

10.				

b. Current Activities
1) Continue with CSHCN Survey
2) Adolescent Health Clinic nurse a member of IEP team
3) Continue to work with partners as council/committee member to improve access to health care and independent living in areas such as housing and transportation.

c. Plan for the Coming Year
The major activity is to complete the survey and analyze survey data using EpiInfo. We will do public service announcements on components of the survey results and provide copies to our partners and families. We will also work on activities for each performance measure pending survey results.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	75	75	88	88.5
Annual Indicator	66.9	72.3	76.9	77.1	86.8
Numerator	852	1273	1109	1125	1386
Denominator	1274	1761	1442	1459	1596
Data Source				Immunization Registry	Immunization Registry
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	88.5	88.5	89	89	89

Notes - 2009
1386 children aged 19-35 months completed Immunization screening in 2009.

Notes - 2008
In 2008, 1125 19 to 35 month olds received full schedule of appropriate immunization.

Notes - 2007
Of 1442 19-35 month old, 1109 received full immunization schedule

a. Last Year's Accomplishments
1) Continue to conduct reminder calls
2) Continue with Immunization walk-in clinic

2) Please note that activities were scaled down due to the H1N1 campaign.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Brochure on age appropriate immunization in the prenatal care packet		X	X	
2. Open Saturday clinic	X	X	X	
3. Identify children that are not up-to-date		X	X	
4. Call parents for Saturday clinic	X	X	X	X
5. Recruitment of data clerks from ARRA grant		X	X	X
6. Continue to enter prepopulated data into WebIZ Registry		X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

1) MCH and ECCS support public awareness activities on age appropriate immunization
2) MCH represents Immunization Program for Developmental Disabilities Council and Head Start Program Community Partners
3) Continue to enter pre-populated data into WebIZ Registry
4) Provide immunization on-site during Shriners Clinic
5) Provide immunization on-site at Children's Developmental Assistance Center

c. Plan for the Coming Year

Continue to work with National Immunization Program for the analysis of the 2007 Immunization Coverage Survey.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	28	31	30	26.5	26.5
Annual Indicator	31.3	22.2	21.5	20.3	22.2
Numerator	37	33	33	32	35
Denominator	1184	1485	1533	1573	1577
Data Source				live birth certificates	Live Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	26.5	26.5	26.5	26	26

Notes - 2009
35 total teens aged 15-17 years delivered in 2009.

Notes - 2008
32 teens 15-17yrs gave birth in 2008.

Notes - 2007
33 births for mothers 15-17 years old in 2007. Denominator revised.

a. Last Year's Accomplishments
1) Family planning services can be accessed at Women's Clinic located at the Commonwealth Health Center
2) MCH and other programs supported and coordinated outreach activities to promote awareness of Family Planning Program by changing the message and attitude surrounding family planning. Through MCH's partners, we increased conducting presentations such as at the Head Start Parents Symposium and Live Teen Talk Show

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family planning ongoing service at the school-based clinic	X	X	X	X
2. Family planning services fees waived for teenagers	X	X	X	X
3. Guests on the Live Teen Talk Show and conduct presentations at middle and high schools and also to parents		X	X	X
4. Set up information table during community events		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1)Preventive services continue to be provided at the school-based clinic
2)Coordinating preventive services with another high school that has a nursing staff
3)Continue to conduct outreach activities at community events and health fairs
4)Key staff participated in the Annual Title X Pacific Basin Family Planning Conference
5)Conducted the Adolescent Health Determinant (AHD) work group
6) Work with partners on activities from AHD work group

c. Plan for the Coming Year
We will be working on activities that were mentioned at the focus group with the school system and partners. Some of the teens recommendations include increase promotion of abstinence and safe sex, presentations that include more visuals, teen speakers (even though they know that being a teen parent is hard they mentioned that there is a show on MTV and they think that 16 year olds will get pregnant so they can be on tv); make available mechanical babies.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81.5	60	60	66	67
Annual Indicator	58.8	65.0	65.9	90.7	78.5
Numerator	1582	1650	1907	691	2099
Denominator	2690	2537	2892	762	2673
Data Source				Dental program	Dental Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	79	79.5	79.5	80	80

Notes - 2009
Of the 2,673 (1st, 5th, and 6th grade) enrollees, 2,099 received protective sealant in 2009. 1st graders data is pending and will be subsequent data submission.

Notes - 2008
First graders only. First sealant application. Of the 762 first graders, 691 students received at least 1 protective sealant in 2008.

Notes - 2007
1,907 1st, 5th, and 6th graders received protective sealant in 2007; 2,892 1st, 5th, and 6th grade enrollees.

a. Last Year's Accomplishments
1) Dental care services can be accessed at 4 private dental clinics by Medicaid participants

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with Public School System for transportation to PH Dental Clinic		X	X	X
2. Purchase fluoride varnish and sealants	X	X	X	
3. Develop database for School Program		X	X	X
4. Media campaign on Oral Health (Medicaid participating private dental clinics are included)		X	X	
5. Set up exhibits during community events and provide toothbrush and toothpaste		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1) Continue School Dental Program that provide sealant and fluoride varnish applications to students, including Rota and Tinian
2) Procure supplies and brochures for the program
3) Conduct outreach activities during community events and health fairs
4) Partner with WIC and Immunization Programs to provide fluoride varnish application service

c. Plan for the Coming Year
We are partnering with ECCS Big Steps for Little Feet Project to provide incentives to parents bringing their children in for dental care because of the information on their child's yellow immunization card. Please note that although we don't target third graders in particular we do conduct oral health awareness campaign to promote healthier dental outcomes by the time children enter school.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	6	6	0	10
Annual Indicator	12.5	12.5	0.0	6.1	6.2
Numerator	2	2	0	1	1
Denominator	15978	15973	16443	16372	16244
Data Source				Death certificates	Death certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	10	6	6	6

Notes - 2009
Only 1 motor vehicle fatality in 2009 for 14 yrs and below.

Notes - 2008
Only 1 MVA death in 2008.

Notes - 2007
Denominator revised

a. Last Year's Accomplishments
1) For the "Week of the Young Child" all agencies including Department of Public Safety gather at one of the public elementary schools to promote awareness on all children's programs
2) Department of Public Safety invited to participate in mini health fairs

3) MCH supported "Drunk Driving" awareness activities

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Revised Health and Safety Manual for child care centers		X	X	X
2. Conducted training on the health and safety manual		X	X	X
3. Continue with referrals to Office of Highway Safety for coupon to assist in the purchase of car seats; we also provide data on deaths caused by motor vehicle crashes		X	X	
4. MCH and Head Start Program Community Partners collaborate to increase awareness on child safety		X	X	X
5. MCH Program Coordinator appointed by governor to serves in the Strategic Prevention Framework State Incentive Grant advisory council addressing underage drinking		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) Revised Health and Safety Manual for child care centers which has information on car seats and seat belts.
2) Conducted training on the health and safety manual
3) Continue with referrals to Office of Highway Safety for coupon to assist in the purchase of car seats; we also provide data on deaths caused by motor vehicle crashes
4) Education and brochures provided to parents including drinking and driving
5) MCH and Head Start Program Community Partners collaborate to increase awareness on child safety
6) MCH a member of the SPF in which underage drinking is a priority focused area

c. Plan for the Coming Year

Continue to partner with other agencies for children's safety awareness including assisting with activities such as check points for driving under the influence, etc. MCH will support and implement activities under the Community Guidance Center Project Brabu in which the Program Coordinator serves on the governor's advisory council.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		80	80	80	33
Annual Indicator		47.8	35.0	19.4	36.9
Numerator		680	485	245	527
Denominator		1422	1385	1266	1427
Data Source				WIC program	WIC program

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	37	38	39	40	40

Notes - 2009
In 2009, 1,427 number of mothers served under WIC program and 527 infants were breastfed at 6 months of age. 154 never breastfed. The implementation of the WIC Program data system has allowed for the program to provided more accurate counts and also the establishment of the clinic for 2 years now has enabled partners to refer to the WIC Program thus the increase in the numerator.

Notes - 2008
WIC data collection for mothers breastfeeding at 6 months started in October 2008. 245 mothers reported breastfeeding at 6 months of age.

Notes - 2007
Data provided by WIC, incomplete 2007.

a. Last Year's Accomplishments
1) Certified Lactation Counseling (CLC) training completed. We now have 6 certified counselors.
2) Received WIC small agency "Most Improved in Breastfeeding" award from the USDA-FNS (see attached)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Contractual service of a master level nurse for training and mentoring on breastfeeding counseling for DPH staff, including WIC Program and private clinics	X	X	X	X
2. Collaborate with WIC Program on the training for certified lactation counseling		X	X	X
3. Working with other program on reinstating CHC as a 'baby friendly' facility (we are also reviewing current policies for revisions)		X	X	X
4. Key staff such as nursery unit nurse, private clinic nurses, WIC Program nurses passed certified lactation counseling exam.	X	X	X	X
5. Grow and Glow Breastfeeding staff training done by Every Mother	X	X	X	X
6. Certified Lactation Counselors providing breastfeeding support in WIC clinic and hospital and women's clinic.	X	X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

1) Contractual services of master level nurse to work with nursing staff in providing breastfeeding education, counseling, and mentoring
2) Breastfeeding Coordinator has recently been recruited for the WIC Program (MCH Program Coordinator was on the interview panel)
3) CLCs provide breastfeeding support in the hospital and WIC Clinic.
4) Breastfeeding video is shown at public health facility waiting areas
5) We are working with programs such as newborn hearing screening to promote breastfeeding
6) Continue with increasing awareness by providing partners, including private clinics, with posters, flyers, and brochures on breastfeeding for their clients

c. Plan for the Coming Year
Although we have "Baby Friendly" policy in place it somehow is not being followed. With the lead of the MCH Program and the WIC Program, we are working with key hospital staff to re-institute the policy. Therefore, we have provided the training and mentoring of nursing staff and now we will focus on the policy. The WIC Program will be implementing the Breastfeeding Peer Counseling program once they recruit the Breastfeeding Coordinator.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	99	99
Annual Indicator	99.3	99.4	97.7	98.3	98.7
Numerator	1323	1414	1353	1244	1096
Denominator	1332	1422	1385	1266	1110
Data Source				EHDI	EHDI
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99	99	99	99.1	99.1

Notes - 2009
In 2009, 1096 of newborn had hearing screening before hospital discharge. Early Hearing Detection and Intervention surveillance system provided us with the data.

Notes - 2008
In 2008, 1244 newborn screened for hearing, 4 positive, 2 left and 2 receiving treatment.

Notes - 2007
1,383 newborns screened before discharge in 2007

a. Last Year's Accomplishments
1) We successfully screened 98.1% of our infants before hospital discharge
2) Conducted family survey -- 80% of families that participated were aware of our program; 92% had seen the television ads or heard the radio ads.
3) Provided training for nurses, audiologist, and early intervention services staff

4) Implemented hearing screening waiver form

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developed EHDI newsletter - will be sent to physicians and Early Intervention Services providers every quarter		X	X	X
2. Conducted family survey		X	X	X
3. Provided training for the nurses, audiologist, EHDI staff on diagnostic equipment		X	X	X
4. Procure supplies for equipment		X	X	
5. Contracted consultant to focus on quality improvement activities		X	X	X
6. Working with the Vital Statistics Office as they update their data collection to the 2003 birth certificate standard (EHDI database is directly linked with this system)		X	X	X
7. Procure contractual services of audiologist and database developer	X	X	X	X
8.				
9.				
10.				

b. Current Activities

1) Continue with public awareness of the EHDI Program
2) Continue to focus on quality improvement activities to reduce the final refer rate to 4%
3) Developed EHDI newsletter to be sent out quarterly to physicians and early intervention services providers (attached)
4) Initiated the gas voucher program to reduce the number of infants lost to follow up
5) Consultant was contracted to focus on quality improvement for our program (we went from a final refer rate of 27% to 14% in 3 months)
6) Continue to modify materials and have materials translated in Chinese and Korean
7) Coordinating parents retreat weekend

An attachment is included in this section.

c. Plan for the Coming Year

1) Continue to include the 1-3-6 model as program benchmarks
2) Create 'road map' that will guide families through the follow up process including early intervention services

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	12.9	44	44	43	60
Annual Indicator	44.6	48.7	50.7	61.7	61.0
Numerator	9211	10335	9961	12155	12000
Denominator	20647	21230	19636	19707	19657
Data Source				RPMS	RPMS

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60	60	55	55	55

Notes - 2009
12000 children without health insurance including 101 visitors derived from RPMS.

Notes - 2008
2551 children 0-17yrs with no insurance. This is attributed to the declining economic situation of the CNMI - closing of garment industry, federalization of immigration, etc.

Notes - 2007
9,961 children 17 years and under without health insurance in 2007. Total children in state revised to reflect new estimate projection.

a. Last Year's Accomplishments
1) Posters and flyers on Medicaid Program are in waiting areas for public health facilities and 4 private health insurance
2) Eligibility assistance provided at Children's Developmental Assistance Center

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide eligibility assistance to CSHCN for Medicaid Program		X	X	X
2. Continue to refer to Medically Indigent Assistance Program		X	X	
3. Provide transportation and translation to Medicaid Program		X	X	
4. Include Medicaid Program information on all print ads focusing on MCH population groups incluing children		X	X	
5. Social Worker stationed at Medicaid Program office one day a week to assist with application process for CSHCN		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1) Include Medicaid Program information on all MCH ads
2) Continue to provide eligibility assistance
3) Continue to work with Finance Unit and Medical Records to improve reporting of health insurance
4) Continue with referrals to Medicaid Program and Medically Indigent Assistance Program, including referrals directly from health care providers (please note that referrals from public health facilities or health care providers are given first priorities to be processed)

5) Provide transportation and translation as requested

c. Plan for the Coming Year
Again, we will continue to work with our community partners such as Head Start Program to enroll children and families into the Medicaid Program. In addition, we are working together to address the staffing shortage at the Medicaid Program. There are currently 3 staff that work on processing applications for the CNMI at the Medicaid Program office.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		50	50	50	30
Annual Indicator		0.0	0.0	25.9	34.8
Numerator		1	1	308	984
Denominator		5059	5220	1188	2824
Data Source				WIC program	WIC program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	35	35	40	40	45

Notes - 2009
There were 2,824 total children under WIC program. A total of 984 children at or above the 85%ile BMI and 2,270 children below the 85%ile BMI.

Notes - 2008
In 2008, 1108 children in the WIC program aged 2-5 yrs. 308 were at or above the 85th percentile.

Notes - 2007
Estimated population 2-5 years in 2008. Data not readily available during this report

a. Last Year's Accomplishments
1) Clinic staff assessed and trained on counseling techniques to motivate participants to adopt healthy behaviors -- Participant Centered Education/Services
2) Implemented the WIC new food packages
3) Staff trained on Basic Nutrition for WIC
4) WIC vouchers can be redeemed at local farmers markets

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Online training for staff nutrition course.	X	X	X	X
2. Participant focus groups conducted to create culturally appropriate, effective nutrition education materials, identify customer services concerns, and identify staff training needs.		X	X	X
3. Second stage of survey of dietary habits of WIC participants (NAFTAN) conducted		X	X	X
4. Online training adopted for intro to WIC, computer system (AIM), and civil rights		X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) Online training in final stages of adoption for staff nutrition course
2) Second stage of survey of dietary habits of WIC participants will be conducted
3) Average WIC caseload up by 18%
4) Conducted participant focus groups to create culturally appropriate, effective nutrition education materials
5) Continue to participate during community events

c. Plan for the Coming Year

1) In planning stage to conduct a public event with a focus on fruits and veggies
2) Recruitment of Nutrition Assistant able to speak Chinese
3) Recruitment of another registered dietician

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		1	1	60	20
Annual Indicator	100.0	100.0	100.0	6.1	5.0
Numerator	1	1	1	76	55
Denominator	1	1	1	1255	1107
Data Source				Birth Certificates	Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5	5	5	5	5

Notes - 2009
In 2009 birth certificate registration, women were generally asked if they use tabacco or smoking during their pregnancy. 2010 revision questions were more detailed about smoking during 1st, 2nd, and 3rd trimesters.
55 pregnant women used tabacco/smoking during their pregnancy in 2009.

Notes - 2008
10% variance of 1266 pregnant women to be surveyed. Preliminary report based on 76 completed surveys. Final result pending completion of 51 remaining data entry.

Notes - 2007
Data on women smoked in the 3 months of pregancy is not available at the time of reporting

a. Last Year's Accomplishments
1) Participated in the Kick Butts Day event
2) Continue to give women the Prenatal Health Book with pregnancy and tobacco information
3) Provided tobacco education during Wise Women Village Project

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Perofrmance measure question is on the newly revised 2003 birth certificate standard form		X	X	X
2. Training to providers and clinical staff on counseling women about smoking at all visits		X	X	
3. Referral to the Quit Line and Tobacco Cessation Program		X	X	
4. Implemented No Smoking No Chewing Policy at government facilities and restaurants		X	X	X
5. Brochure included in the prenatal care booklet and also in the prenatal care packet		X	X	
6. MCH staff serve as member of Commonwealth Cancer Association in which we focus activities on effects of smoking and pregnancy and supported Clean Air Act.		X	X	X
7.				
8.				
9.				
10.				

b. Current Activities
1) Education and counseling provided at prenatal care visits
2) Implemented 2003 birth certificate standard form which asks for smoking in the last three months of pregnancy
3) MCH participated in the World No Tobacco Day event
4) Continue with referral to cessation program
5) Continue with prenatal care ads that include information on the effects of smoking

c. Plan for the Coming Year
Although we have no formal plans to expand the smoking cessation program, we continue to work with our partners to provide counseling and resources during women's health exams and prenatal care visits and during community events. We have ongoing working partnership with

Tobacco Cessation program in that we bring the completed referral form to their office and they will initiate contact immediately. We will continue to participate in no smoking events with a focus on tobacco and pregnancy.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50.5	5	5	1	20
Annual Indicator	0.0	0.0	0.0	18.9	0.0
Numerator	0	0	0	1	0
Denominator	4528	4645	4762	5279	5470
Data Source				Death certificates	Death certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	0	0	0	0	0

Notes - 2009
No suicide fatality for teens 15-19 yrs of age in 2009.

Notes - 2008
In 2008, only 1 suicide death 15-19 yrs.

Notes - 2007
No case of suicide for 15-19 years teens in 2007

a. Last Year's Accomplishments
1) MCH participated in the Micronesian Youth Summit held in Saipan - was on the panel for prevention of teen pregnancy and also displayed information.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Counseling provided at school based clinic	X	X	X	X
2. Provides referral and follow-up with Community Guidance Center		X	X	
3. MCH one of the sponsor for suicide counseling training in 2010.		X	X	X
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
1) Continue to make counseling available and accessible to teens
2) Continue to work with our partners to in events focusing on teen
3) School-based clinics information on web-sites addressing teen issues including suicide
4) MCH supports Community Guidance Center's training on suicide counseling

An attachment is included in this section.

c. Plan for the Coming Year
We will be working with our partners and the students on activities that address depression, low-self esteem, suicidal thoughts, etc. Please note that when we work with teens we include life-building skills such as decision-making skills, and we encourage them to communicate with parents on what they are going through. We give them tips to differentiate being sad and being depressed.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1	1	1	1	1
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	1	1	1	1	
Denominator	1	1	1	1	
Data Source				No high risk facility	No high risk facility
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1	1	1	1	1

Notes - 2009
CNMI is excluded from this performance measure due to no high risk facility on island.

Notes - 2008
CNMI is excluded from this PM. There is no high risk facility in the CNMI.

Notes - 2007
CNMI is excluded from this PM. There is no high risk facility in the CNMI.

a. Last Year's Accomplishments
CNMI is waived from reporting on the national performance measure

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CNMI is waived from reporting on this performance measure				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CNMI is waived from reporting on the national performance measure

c. Plan for the Coming Year
CNMI is waived from reporting on the national performance measure

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	31.4	28	29	29.9	30
Annual Indicator	28.2	22.9	29.1	17.2	28.2
Numerator	375	326	403	219	316
Denominator	1332	1422	1385	1272	1119
Data Source				Birth registration	Birth registration
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	30.9	31	31	31.1	31.1

Notes - 2009
There were 316 pregnant women received prenatal care in the first trimester.

Notes - 2008
PNC visit in 1st trimester in 2008 birth registration showed 213.

Notes - 2007
Derived from Birth certificates. 403 first visit in the 1st trimester 2007.

a. Last Year's Accomplishments

1) Conducted a survey of postpartum women to evaluate access to prenatal care in the CNMI

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medicaid Program information included in all prenatal print ads		X	X	
2. Information on the 4 private clinics accepting Medicaid is provided to community (these private clinics provides prenatal care service)		X	X	
3. Eligibility assistance available for pregnant women		X	X	
4. Conducted postpartum survey to evaluate prenatal care		X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) Partner with Family Planning, BCCSP, and hospital OB/GYN unit on public awareness campaign on prenatal care visits
2) Continue to provide Medicaid Program information on all prenatal care public awareness materials
3) Continue with provide information on 4 private health clinics that participates in the Medicaid Program and provide prenatal care service.
4) Still working on the computerization of the delivery log manual

c. Plan for the Coming Year

We will be initiating a prenatal care village project. The postpartum survey results show 4 villages with women not accessing prenatal care visits. We will be going to each village once a month to provide services to women that have not had a first prenatal visit.

D. State Performance Measures

State Performance Measure 1: *The percent of unplanned pregnancies of birth (per 1,000) for women aged 15-44 years*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		52.5	50	75	70
Annual Indicator	55.4	57.8	78.8	66.4	60.1
Numerator	738	822	1091	844	673
Denominator	1332	1422	1385	1272	1119
Data Source				Family Planning Program	Family Planning
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	70	65	65	60	

Notes - 2009
60.1% unintended pregnancies in 2009.

Notes - 2008
Estimated 66.7 percent reported unplanned pregnancies from the 196 mothers in 2008. Full report on family planning on prenatal care visits will be implemented for the proceeding years.

Notes - 2007
Total intended pregnancies in 2007 is 294, unintended 1091

a. Last Year's Accomplishments
A major success this past year has been the increase in community outreach and education for family planning services. Many of last project year's goals centered on increasing awareness of family planning benefits and options through outreach initiatives. The program made huge strides this past year in becoming more known and accepted within the community and changing the message and attitude surrounding family planning. To accomplish this, the program developed a written community education plan and implemented awareness efforts through a wide range of promotional strategies.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Medicaid participants can access health care services at 4 private health clinics	X	X	X	X
2. Title X funds supplements family planning services and allows for fees to be waived for teenagers	X	X	X	X
3. Trained staff - Women's Health Nurse Practitioners, Nurses, Nursing Assistants provide services at public health clinics and school based clinics	X	X	X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Title X Family Planning offers long acting reversible contraceptive (LARC) choices which are known to be highly effective and easy to use resulting in fewer unintended pregnancies.

c. Plan for the Coming Year
We will continue with providing information and education on family planning program and ensuring availability of contraceptives at all sites providing such services.

State Performance Measure 2: *Percent of women who have ever received a pap smear.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	**2005**	**2006**	**2007**	**2008**	**2009**

Performance Data					
Annual Performance Objective		7.9	7.9	7.9	8
Annual Indicator	7.9	10.0	11.0	11.1	10.4
Numerator	2808	2512	2623	2533	2324
Denominator	35634	25140	23945	22760	22396
Data Source				BCSP & Wise Women Project	BCSP & Wise Women
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8	8	8	10	

Notes - 2009
2324 women received a pap smear in 2009.

Notes - 2008
There were 2509 number of women ever received pap smear in 2008.

Notes - 2007
Denominator revised.

a. Last Year's Accomplishments
1) The Governor of the CNMI proclaimed January as National Cervical Cancer Awareness Month.
2) Celebrity Bagging activities were conducted for 4 hours every Saturday in January at the local supermarkets. Cancer survivors, community members, public health program managers and partners were celebrities who bagged groceries and educated store customers on cervical cancer related information.
3) Cervical Cancer Health Fairs were conducted on Saipan, Rota and Tinian with partners where an exam room/site was secured to conduct Pap tests. State women's healthcare providers volunteered their time to conduct the Pap tests. The organizing committee partnered with the H1N1 Flu Campaign for Saipan's Cervical Cancer Health Fair where H1N1 vaccines were being offered.
4) MCH a partner of Wise Women Village Project

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partner with Breast and Cervical Cancer Screening Program (BCSP)	X	X	X	X
2. Continue to refer low income women to BCSP and Wise Women Village Project	X	X	X	
3. Participated in the Cervial Cancer Awareness Month and Marianas March Against Cancer		X	X	X
4. Provide information on private health clinics that accept Medicaid		X	X	
5. Review BRFSS results		X	X	X
6. Cervical Cancer Health Fairs held in Saipan, Tinian, and Rota and pap tests were provided by public health providers	X	X	X	X
7.				
8.				
9.				
10.				

b. Current Activities
1) Revising CNMI Breast and Cervical Screening Program (BCSP) policy and protocols to ensure 100% of cervical cancer screening results are received by the program and entered in to the program's tracking database (CaST).
2) Revising CNMI Breast and Cervical Screening Program policy and protocols to ensure 100% of abnormal cervical cancer screening results receive appropriate and timely follow up.
(MCH staff working with BCSP on 2 activities above)

c. Plan for the Coming Year
1) By January 2011, conduct awareness campaign on cervical cancer to at least 300 women ages 21 and older including importance of pap test.
2) By June 2011, 90% of program clients will be rescreened for cervical cancer.
3) By June 2011, healthcare provider will receive 100% of cervical cancer related lab results.
(MCH will work with BCSP to achieve above objectives)

State Performance Measure 3: *Percent of women who have ever received a mammogram.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		12.8	12.8	12	12
Annual Indicator	12.8	11.9	5.9	5.4	14.9
Numerator	1014	1087	558	521	1479
Denominator	7949	9160	9387	9599	9958
Data Source				Radiology	Radiology
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12	12.5	12.5	11	

Notes - 2009
1479 women received a mammogram in 2009.

Notes - 2008
The number of mammogram decrease due to lack of professional staff from July to November 2008.

Notes - 2007
The decrease in mammography was due to lack of Radiologist in 2007. Denominator revised.

a. Last Year's Accomplishments
1) Identified and contracted 2 radiologists out of Guam to read and interpret mammogram films as well as conduct follow up procedures. With the radiologists on board, the CNMI was able to conduct 1,489 mammograms.
2) The Breast and Cervical Screening Program worked with its partners, healthcare providers and the cancer coalition to launch a Breast Cancer Screening Campaign wherein clinical breast exams (CBE) and Pap smears were conducted at various government and private agencies. The procedures were conducted by state healthcare gynecologists using the public health mobile clinic. Blood pressure, blood sugar and BMIs were conducted on site with the partnership of the Diabetes Prevention and Control Program (DPCP), the Diabetes Coalition and volunteer nurses. With the screening and education activities identified above, the partnership was able to reach 189 women.
2) Breast Cancer health forums were conducted on the islands of Saipan, Tinian and Rota where

program staff, healthcare providers, WIC personnel and a cancer coalition member presented to registered participants that included breast cancer survivors and interested community members. Topics included Breast Anatomy, Breast Cancer, Identifying and Reducing Risk Factors, Breastfeeding and Breast Cancer, CNMI Breast and Cervical Screening Program, and the Commonwealth Cancer Association.
3) Celebrity Bagging activities were conducted for 4 hours every Saturday in October at the local supermarkets. Legislators, breast cancer survivors, community members, public health program managers and partners were celebrities who bagged groceries and educated store customers on breast cancer related information.
4) Conducted activities in the community during Breast Cancer Awareness Month in October.
5) MCH a partner for Wise Women Village Project

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to refer low income women to BCSP and Wise Women Village Project	X	X	X	X
2. Partner with Breast and Cervical Cancer Screening Program (BCSP)	X	X	X	X
3. Participated in Breast Cancer Awareness month activities		X	X	
4. MCH a partner in Wise Women Village Project which includes clinical breast exam and education	X	X	X	X
5. Review BRFSS results		X	X	X
6. Breast Cancer Screening Campaign conducted wherein clinical breast exams (CBE) provided to women at various government and private agencies by public health providers				
7. Breast Cancer health forums were conducted on the islands of Saipan, Tinian and Rota		X	X	
8. Identified and contracted 2 radiologists out of Guam to read and interpret mammogram films as well as conduct follow up procedures.	X	X	X	X
9.				
10.				

b. Current Activities
1) Continue to increase awareness on self-examination, clinical breast exam, and mammogram.
2) Continue to exhibit during community events with partners
3) Waive mammogram fees during Breast Cancer Awareness Month
4) MCH member of committee developing plans for the upcoming Breast Cancer Awareness Month

c. Plan for the Coming Year
1) By October 2010, conduct awareness campaign on breast cancer to at least 200 women ages 40 and older.
2) By June 2011, 75% of women screened by the CNMI Breast and Cervical Screening Program (BCSP) for breast cancer will be 50 -- 64 years of age.
3) By June 2011, increase program partners by 5%.
(Please note that MCH will be working with BCSP to achieve above objectives)

State Performance Measure 4: *Percent of eligible infants with disabilities under the age of 1 year receiving early intervention services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		132	132	30	45
Annual Indicator	132.9	17.6	30.3	3.2	3.6
Numerator	177	25	42	4	4
Denominator	1332	1422	1385	1266	1109
Data Source				CDAC	CDAC
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	45	45	50	50	

Notes - 2009
79 infants were referred to CDAC and only 1 received early intervention services.

Notes - 2008
In 2008, 55 infants were refered for early intervention. Four (4) infants received early intervention services but two (2) left the island since.

Notes - 2007
42 under 1 year old C DAC services in 2007

a. Last Year's Accomplishments
1) Conducted public awareness information regarding early intervention services during Developmental Disabilities Awareness Month
2) Conducted presentations to physicians on the early intervention services program
3) Went to high schools and talked about 'careers' in early intervention services

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue with child find and public awareness activities		X	X	
2. Held 'talk story' session with hospital nurses - nursery, pediatric, NICU, labor and delivery, children's clinic, etc - on how to improve referral process		X	X	X
3. Public School System Early Intervention Services provided training on developing Individualized Family Service Plan, Interdisciplinary Team, etc.		X	X	X
4. Continue to provide developmental screening including one saturday a month (promoting developmental screening as an extension of well baby visit)	X	X	X	X
5. Continue with awareness campaign on healthy growth and development		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) Children's Developmental Assistance Center (C*DAC) is currently providing developmental screening one Saturday a month in addition to regular working hours
2) Working with daycare centers on logistics to go about conducting developmental screening on-site
3) Continue to increase awareness on baby's growth and development following CDC's Learn the Signs. Act Early Campaign
4) Continue to provide growth and development checklists to parents at all the clinics
5) As a result of the 'talk story' session with nurses, we are promoting Developmental Screening as an extension of well baby/child visits (parents think that developmental screening is for problems only - like something is wrong with their babies)
6) Continue with our child find and public awareness activity with our partners.
7) Continue to work with partners to increase referrals and ensure follow-up
An attachment is included in this section.

c. Plan for the Coming Year
We will continue with providing developmental screening one Saturday a month, at the WIC and Immunization Clinics. We will also be working with daycare centers to conduct the screening. This has been one of the work plan activities but due to H1N1 and HPV School campaign last year it was put on hold.

State Performance Measure 5: *The rate of chlamydia for adolescents aged 13-19 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		7	7	6	6
Annual Indicator	9.3	3.0	4.1	3.3	5.0
Numerator	59	22	30	25	38
Denominator	6355	7241	7386	7544	7664
Data Source				HIV/STD program	HIV/STD Program
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6	6	5	5	

Notes - 2009
In 2009, 38 children ages 13-19 were positive for chlamydia.

Notes - 2008
In 2008, 25 children ages 13-19 were positive for chlamydia.

Notes - 2007
13-19 year old with chlamydia in 2007. Denominator revised.

a. Last Year's Accomplishments
One of the accomplishment is our work with the schools in conducting the adolescent health determinant session. Each public high schools were able to not only bring the students to the session but also assisted in the session. As has been mentioned, one other public high school opened a health center and recruited a nurse. We provided them with educational materials. MCH supported the HPV School Campaign.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide services including counseling at school based clinics	X	X	X	X
2. Partnered with new school based clinic at another public high school	X	X	X	X
3. Brochures available at all public health facilities including private clinics		X	X	
4. Women's Health Nurse Practitioner stationed at HIV/STD Resource Center and the Adolescent Health Clinic	X	X	X	X
5. MCH and other public health programs working with SPC to recruit a staff that will be stationed at the Lab Unit to assist with identification and tracking		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) We are granted permission by Lab Unit to have one MCH staff view their system to see how many are being tested and how many are positive
2) SPC is working with preventive programs to recruit a staff to be stationed at the Lab Unit to assist programs with identification and tracking for positive results
3) Continue to partner with HIV/STD Prevention Programs, Family Planning on activities focusing on prevention of sexually transmitted diseases
3) Working with one other public high school that opened a health center and recruited a nurse for thier school.
4) Finishing adolescent health determinant report
5) Continue to provide services at school-based clinics
6) Provide educational materials to all the clinics, including Rota and Tinian.

c. Plan for the Coming Year

We will continue our work with our partners on activities to prevent STIs. In addition, we will be forming a group to address results of the adolescent health determinant session and develop activities to address some of the issues.

State Performance Measure 6: *The degree to which State provides nutrition education information to children aged 6 through 11 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	71.5	50	50	52.5	20
Annual Indicator	20.3	18.2	15.1	13.7	14.4
Numerator	468	800	525	663	527
Denominator	2310	4400	3485	4837	3655
Data Source				Nutritionist	Estimated
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	20	20	25	25	

Notes - 2009
Estimated figures pending data from source, CREES NMC. Public Health does not have nutritionist since last year.

Notes - 2008
Total enrollment for 6-11yrs. Nutrition education est. at 662.

Notes - 2007
Preliminary figure for nutrition education 6-11 yr old.

a. Last Year's Accomplishments
1) Exhibit during schools' cultural day or health fair
2) Conduct presentations on 'healthy eating' at schools as requested
3) WIC Program provides support in training clinical staff in nutrition counseling

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in school events and health fairs		X	X	X
2. MCH sponsored 'Cooking with Colors' live tv program		X	X	
3. Partnered with Public School System nutritionist for counseling needs of families	X	X	X	X
4. Referral source to WIC Program		X	X	X
5. Cooking demonstrations at Sabalu Market were held for the month of January as an activity for Cervical Cancer Awareness Month		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1) MCH supports live tv ads focusing on this age group (did print ads last year)
2) Continue to support cooking contests for this age group
3) In collaboration with ECCS Big Steps for Little Feet project, we provided incentives to encourage physical activity such as jump ropes.
4) Coordinated activities with partners such as WIC Program out in the community for Week of the Young Child

c. Plan for the Coming Year
CNMI Department of Public Health submitted the Affordable Care Act (ACA) Home Visiting Program grant application. If approved this will help us expand our work to the homes in educating our families about nutrition and physical fitness.

State Performance Measure 7: *The percent of pregnant women that are screened for chlamydia.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2005	2006	2007	2008	2009

Data					
Annual Performance Objective	98	99	100	100	55
Annual Indicator	96.2	124.5	102.9	49.8	38.6
Numerator	1281	1770	1425	633	432
Denominator	1332	1422	1385	1272	1119
Data Source				Lab	Women's Clinic
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55	60	60	65	

Notes - 2009
Numbers provided by Women's Clinic only. Significant decrease in total tested could be a result of the recent closure of one of the wellness clinics among other state factors.

Notes - 2008
estimated number of pregnant women screened.

Notes - 2007
Provisional figure for pregnant women screened for chlamydia in 2007

a. Last Year's Accomplishments
BRFSS was conducted last year in collaboration with Department of Commerce's Central Statistics Unit. We provided public and private clinics with Prenatal Care booklet that has information on STD/HIV screening and counseling.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Counseling and education provided at prenatal care visits		X	X	
2. Brochures available at public health clinics and private clinics (brochures included in prenatal care packet)		X	X	
3. Medicaid accepted at four private health clinics that provide prenatal care visits	X	X	X	X
4. Medicaid participating clinics included in prenatal care ads		X	X	
5. Continue to give women prenatal care booklet which include STD/HIV information		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
As was mentioned, MCH Program is working with other programs on quality improvement activities. One of this is
to develop 'road map' on the services provided at public health clinics. As we are working to develop a road map for the hearing screening program, MCH will be working with its partners to develop one for prenatal care visits to guide our women through the system thus creating more user friendly environment.
We continue with including STI brochures in prenatal care packet.

c. Plan for the Coming Year

We will be reviewing BRFSS report and again work with internal and external partners to address activities to increase utilization of preventive health services. We are working to implement the Prenatal Village Project.

E. Health Status Indicators

Introduction

MCH Program is committed to ensuring healthy births, reducing the incidence of low birth weight, and improving the health status of CNMI's children. Moreover, improvement in the health of the CNMI's infants, children, and adolescent population is the result of our work with our partners. We track health status indicators to assist us to direct public health efforts out to the community. We provide the community with a picture of their health status through public service announcements, meetings with target groups, health data reports, and presentations. We provide information via charts and graphs as part of our exhibits. We just recently worked with Head Start Program's community assessment in which we conducted presentations on children's health to parents, leadership team, etc. The MCH Program's efforts to improve the health status of pregnant women and children have been successful over time as evidenced by expansion of Medicaid to private health and dental clinics, eligibility assistance, targeted outreach, risk reduction education, and development of comprehensive activities. We work with our partners to maximize scarce resources that support shared goals.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.4	8.0	5.8	5.8	7.8
Numerator	99	114	80	74	87
Denominator	1332	1422	1385	1266	1110
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

89 low birth weight in 2009 with 1109 live birth.

Notes - 2008

77 low birth weight in 2008 with 1266 live birth.

Notes - 2007

80 low birth weight in 2007.

Narrative:

There is an increase in our numbers of infants weighing less than 2500 grams in the 2009. However, we have also a decrease in live births giving us a smaller number in our denominator (1266 in 2008 and 1108 in 2009). The closing of the garment industry and the federalization of immigration are contributing factors to the decrease in live births. Many of our non resident workers are women of childbearing age and most have gone back to their home country. We will continue working with our prenatal care ad campaign, refer pregnant women to Medicaid

Program, and provide eligibility assistance as strategies to improve birth outcomes. We are hopeful that we will be able to get better reporting of mother's information on the newly revised birth certificate to identify maternal risk factors such as smoking for this indicator and also for 1B, 2A, and 2B.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.5	7.0	5.3	3.9	7.0
Numerator	87	100	73	50	78
Denominator	1332	1422	1385	1266	1110
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
81 singleton less than 2500g

Notes - 2008
Twenty (20) were preterm at <37 gestational age. There were 12 sets of twins - the most we have had in the CNMI.

Notes - 2007
73 singleton births less than 2,500 grams in 2007

Narrative:
This health indicator removes the impact of multiple births on the low birth weight rate. Although we had 4 sets of twin in 2009 one twin weighed more than 2500 grams. Our highest percent of LBW births was in 2007 (7) and as can be noted we had the highest number of live births that year also (1422). In 2009 4.2 percent of our infants were born weighing less that 2500 grams which is lower compared to 8.46 percent of Guam for 2004. We will continue with same strategies as the first indicator.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.0	1.1	0.5	0.2	0.5
Numerator	13	15	7	3	5
Denominator	1332	1422	1385	1266	1110
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
5 very low birth weight <1500g. All 5 were preterm less than 37 gestational age.

Notes - 2008
3 very low birth weight <1500g. 2 out of 3 were preterm less than 37 gestational age.

Notes - 2007
7 Very low birth weight in 2007

Narrative:
For the past three years we have not had live multiple births weighing less than 1500 grams. There has been no significant increase for the past 3 years. In reviewing birth certificate information these two babies were born to Pacific Islander mothers and are Medicaid enrollees. Our strategies again remain the same for the health status indicators 1A, 1B, 2A, and 2B. We refer Medicaid enrollees to private clinics for prenatal care and continue to provide brochures to public health and private clinics. We also refer these babies to early intervention services to ensure follow up and to monitor growth and development

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.8	0.9	0.5	0.2	0.5
Numerator	11	13	7	3	5
Denominator	1332	1422	1385	1266	1110
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
5 singleton very low birth weight <1500g; 2 preterm births.

Notes - 2008
3 singleton very low birth weight <1500g; 2 preterm births.

Notes - 2007
7 singleton very low birth weight

Narrative:
For the past three years we have not had live multiple births weighing less than 1500 grams. There has been no significant increase for the past 3 years. In reviewing birth certificate information these two babies Pacific Islanders and the mothers are Medicaid enrollees. Our strategies again remain the same for the health status indicators 1A, 1B, 2A, and 2B. We refer Medicaid enrollees to private clinics for prenatal care and continue to provide brochures to public health and private clinics. We also refer these babies to early intervention services to ensure follow up and to monitor growth and development

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	18.8	0.0	0.0	18.3	6.2
Numerator	3	0	0	3	1
Denominator	15978	16395	16443	16372	16244
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Only 1 fatal unintentional injury for children 14 and less.

Notes - 2008
Three 0-14 yrs old unintentional injury mortality in 2008. One due to drowning, 1 due to MVA, and one due to seizure disorder.

Notes - 2007
Zero death unintentional injuries in 2007. Denominator revised.

Narrative:
The cause of death from unintentional injuries among children aged 14 years and younger in the CNMI was to allergic reaction. There were two intentional deaths - gunshot - last year. Although we do not have a formal injury prevention program we continue public awareness on child safety, revised the health and safety manual for child care providers and training with our partners.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	12.5	0.0	0.0	6.1	6.2
Numerator	2	0	0	1	1
Denominator	15978	16395	16443	16372	16244
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?					Final

Notes - 2008
1 MVA death in 2008.

Notes - 2007
No MVA fatality for 14yrs and younger in 2007

Narrative:

Over the 5 year period we had only 4 deaths among children aged 14 years and younger due to motor vehicle crashes. MCH Program will be working with Community Guidance Center to address underage drinking in the CNMI. During Child Safety Awareness event parents of children that have died from motor vehicle crashes particpate in events. Again per 2007 YRBS results for middle school the percentage of middle school students who never or rarely wore a seat belt when riding in a car increased from 12.2 in 2003 to 15.7 in 2007. We have to continue our public education awareness with our partners.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7.6	9.2	19.0	9.7	19.6
Numerator	1	1	2	1	2
Denominator	13123	10838	10516	10271	10198
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2 MVA fatality.

Notes - 2008
1 MVA death 15-24yrs old in 2008.

Notes - 2007
There were only 2 MVA mortality aged 15-25 years in 2007. Denominator revised from 14111 to 10516 to reflect the latest population.

Narrative:
The Adolescent Health Determinant work group identified alcohol and other drug use as the important/most common and/or most concerning adolescent issues related to 1) Behaviors that contribute to unintentional and intentional injuries; 2) Sexual activity that leads to unintended pregnancy and sexually transmitted diseases 3) Mental Health and 4) Alcohol, Tobacco, and other drug use. Furthermore, students ranked alcohol and other drug use the highest amongst the list of priority needs. We will be working with the schools, parents, and adolescents to provide activities in this need. The two deaths are both 20 year olds.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7,597.9	6,770.4	2,882.7	2,504.3	1,391.3
Numerator	1214	1110	474	410	226
Denominator	15978	16395	16443	16372	16244
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
226 total non fatal injuries for children less than 15 yrs

Notes - 2008
The top 3 nonfatal injuries are:
1) Accidental falls
2) stings/bites
3) cut piercing object

These numbers are from ER visits.

Notes - 2007
Number of children age 14 years and younger unintentional injuries was 681 in 2007

Narrative:
The three causes of nonfatal injuries are the same as in 2008: accidental falls, stings/bites, and cuts/piercing objects. We continue to provide the narrative for the Health and Safety Manual for childcare centers and relative care providers that participate in the Childcare Program. The ECCS Project continues to provide partners with injury prevention information as well as health kits. Instead of providng presentation on Immunization, Oral Health, etc. Public Health's topic focused on "what parents can do to prevent injuries". We do not have a formal injury prevention program.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	206.5	206.6	150.3	61.1	166.2
Numerator	33	33	24	10	27
Denominator	15978	15973	15966	16372	16244
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
There were 27 MVA nonfatal injuries with children less than 15 yrs

Notes - 2008
The numbers are from ER visits.

Notes - 2007

There were 24 children 14 years and younger in non-fatal MVA in 2007.

Narrative:
When we were reviewing our data with our partners we heard alot of "WOW, What happened". Then they also realized why they see me or other MCH Program staff in majority of partners events or at community events. As MCH Program, we do work with our partner for public awareness on seat belt use, proper car seat, drunk driving, etc. There was a training conducted last year to the data enterers and this may have to do with increased capacity to code a diagnosis.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	866.1	599.7	351.8	311.6	147.1
Numerator	105	65	37	32	15
Denominator	12123	10838	10516	10271	10198
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
There were 15 MVA injuries for 15-24 yrs of age.

Notes - 2008
32 15-24yrs old nonfatal MVA injuries in 2008.

Notes - 2007
37 non-fatal MVA injuries among 15-24 years old in 2007. Denominator revised from 14111 to 10516 to reflect the latest population.

Narrative:
Although there has been many efforts made by partners such as Department of Public Safety such as check points for driving under the influence, car seat and seat belt use, pedestrian safety, etc., there still was an increase in our rate. MCH has not been very active with this age group as in the past. But the opportunity is there since the Coordinator is serving as a member of the Governor's advisory council for the Project Brabu out of the Community Guidance Center that will address underage drinking as one of its priority.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	22.9	20.3	11.9	8.6	15.1
Numerator	58	52	30	22	39

Denominator	2529	2567	2517	2544	2582
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
39 cases of chlamydia for women 15-19 years of age.

Notes - 2008
22 cases of chlamydia 15-19 yrs olds in 2008.

Notes - 2007
30 15-19 women positive chlamydia. Denominator revised from 2658 to 2517 to reflect the latest population.

Narrative:
There has been a significant decrease in the chlamydia rate for this target group from 2005-2008. However, we see an increase this year. The opening of a school-based clinic at another high school has provided students another access point for testing. Per 2007 YRBS the percentage of high school students who ever had sexual intercourse increased from 48.4 in 2005 to 49.7 in 2007. Then there was a decrease in condom use from 43.1 in 2005 to 40.1 in 2007. Condoms are provided to the school counselor and are available at the school-based clinics. We will continue to work with our partner and adolescents to address this issue.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	4.4	3.7	5.5	2.1	5.2
Numerator	128	66	89	32	74
Denominator	29226	17696	16320	14888	14156
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Notes - 2009
74 cases of chlamydia for women aged 20-44.

Notes - 2008
32 women with chlamydia aged 20-44yrs old in 2008.

Notes - 2007
89 women 20-44 yrs positive chlamydia. Denominator revised to reflect the latest population.

Narrative:

Although, STD testing is provided at all the public health centers and at the 6 private clinics in which 4 accepts Medicaid, we see a significant increase of reported case of chlamydia in 2009. We need to work to improve a more user-friendly service for women coming in for STD testing or even pap test. All fees have to be paid before they can go to the lab to drop off the specimen. We also need to put more effort into awareness of testing, treatment, and partner tracking. We get our data from Lab and HIV/STD Prevention Program. Per Lab there was an increase in the number of STD testing in 2009. We want to look at the number of females versus males and also a breakdown in age group so we can do focused messages with our partners.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	7	1	1	1	1	1	1	1
Children 1 through 4	5335	110	0	0	1919	2315	991	0
Children 5 through 9	5243	9	0	0	1580	2540	1114	0
Children 10 through 14	5621	9	0	0	1461	2975	1176	0
Children 15 through 19	4972	33	0	0	1072	2989	878	0
Children 20 through 24	6261	68	0	0	4147	1647	396	3
Children 0 through 24	27439	230	1	1	10180	12467	4556	4

Notes - 2011
7 figure is invalid. number of infants included in 1-4 years.

Figures includes infants less than 1 year olds.

Narrative:
Again, please note that the decrease in the Asian demographics may be due to the closing of garment industry federalization of immigration. Although some opted to stay many also left back to their home country. This demographics is used to assist us in allocation of resources for each of the level of the pyramid. There are also Pacific Islanders moving away from the CNMI for job opportunities and schools.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	7	0	0

Children 1 through 4	5335	0	0
Children 5 through 9	5243	0	0
Children 10 through 14	5621	0	0
Children 15 through 19	4972	0	0
Children 20 through 24	6261	0	3
Children 0 through 24	27439	0	3

Notes - 2011
no breakdown for infants, combined with 1-4 years. number if infants included in 1-4 yrs.

combined with infants

Narrative:
The largest ethnic group in the CNMI is Asians and Pacific Islanders.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	1	0	0	0	1	0	0	0
Women 15 through 17	35	0	0	0	5	26	4	0
Women 18 through 19	65	0	0	0	10	50	5	0
Women 20 through 34	743	6	0	0	384	344	9	0
Women 35 or older	265	3	0	0	198	61	3	0
Women of all ages	1109	9	0	0	598	481	21	0

Notes - 2011
Total live births from Birth Certificates

Narrative:
There has been a decline in our population of non-resident females due to the closing of garment factories and federalization of labor and immigration laws. There is also a misconception among the guest workers that if they have a baby on U.S. soil, they can stay. Majority of the babies born last year were to Filipino and Chinese mothers. This also provides us with challenges as they don't seek early and continuous prenatal care and do not qualify for Medicaid Program because they are not U.S. Citizens. However their babies does qualify for all program here in the CNMI.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	1	0	0
Women 15 through 17	35	0	0
Women 18 through 19	65	0	0
Women 20 through 34	743	0	0
Women 35 or older	265	0	0
Women of all ages	1109	0	0

Notes - 2011

Narrative:
A review of the birth certificate database did not have any Hispanic or latino as ethnicity. In the CNMI we have a high number of Asians in our population.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	5	0	0	0	2	3	0	0
Children 1 through 4	1	0	0	0	0	1	0	0
Children 5 through 9	0	0	0	0	0	0	0	0
Children 10 through 14	2	0	0	0	0	2	0	0
Children 15 through 19	2	0	0	0	0	2	0	0
Children 20 through 24	2	0	0	0	1	1	0	0
Children 0 through 24	12	0	0	0	3	9	0	0

Notes - 2011
Total of 12 mortality for 0-24 yrs.

Narrative:
The death certificate data for children by is readily available from the Office of Health and Vital Statistics since they have their own standalone database. In 2009, there were 233 deaths to children ages 0-24.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	5	0	0
Children 1 through 4	1	0	0
Children 5 through 9	0	0	0
Children 10 through 14	2	0	0
Children 15 through 19	2	0	0
Children 20 through 24	2	0	0
Children 0 through 24	12	0	0

Notes - 2011

Narrative:
A review of the death certificate database did not have any Hispanic or latino as ethnicity. In the CNMI we have a high number of Asians in our population.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	21171	161	0	0	6032	10819	4159	0	2009
Percent in household headed by single parent	18.8	0.0	0.0	0.0	37.6	52.2	9.6	0.6	2009
Percent in TANF (Grant) families	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Number enrolled in Medicaid	2349	5	0	1	1620	723	0	0	2009
Number enrolled in SCHIP	2349	5	0	1	1620	723	0	0	2009
Number living in foster home care	19	0	0	0	0	17	2	0	2009
Number enrolled in food stamp program	6871	27	0	0	1869	4975	0	0	2009
Number enrolled in	2221	15	0	0	650	1556	0	0	2009

WIC									
Rate (per 100,000) of juvenile crime arrests	1082.3	0.0	0.0	0.0	82.9	898.3	101.3	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	2.6	0.0	0.0	0.0	22.6	77.4	0.0	0.0	2009

Notes - 2011
Data derived from HIES 2005.

Estimated number WIC program recipients pending data from source, WIC Program.

Est. numbers for foster care pending source, DYS.

Narrative:
The economic downturn has hit families particularly hard in here in the CNMI. Nearly all state assistance programs have seen an increase in the number of children served from last reporting year. This is evident with headlines such as NMI Nutrition Assistance Program seeks $9 million more for food stamps; Over 700 families on government's housing assistance wait list; Habitual offender a problem in the CNMI; Theft case involving youths up; 74 students remain on Head Start's wait list, etc. We expect a drop in population of children as families move out of the state for employment. Native Hawaiian or Pacific Islanders include the two indigenous ethnic group in the CNMI -- Chamorros and Carolinians. The ECCS Project addresses early childhood education by working with its partners to increase literacy, enroll children in child care programs or Head Start, and provide parenting classes and support.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	21171	0	0	2009
Percent in household headed by single parent	0.0	0.0	0.0	2009
Percent in TANF (Grant) families	0.0	0.0	0.0	2009
Number enrolled in Medicaid	2349	0	0	2009
Number enrolled in SCHIP	2349	0	0	2009
Number living in foster home care	19	0	0	2009
Number enrolled in food stamp program	6992	0	0	2009
Number enrolled in WIC	19	0	0	2009
Rate (per 100,000) of juvenile crime arrests	1082.3	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	2.6	0.0	0.0	2009

Notes - 2011

estimated number enrolled in WIC

estimated number of foster home care

Narrative:
Again, please note that Pacific Islanders and Asians are the predominant ethnicity in the CNMI.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	0
Living in rural areas	21171
Living in frontier areas	0
Total - all children 0 through 19	21171

Notes - 2011
Data derived from the 2005 HIES

Narrative:
The postpartum survey result provided us a programs again of the challenge of transportation to our MCH population groups. There is no public transportation available here in the CNMI. Again, the survey results revealed that pregnant women that lived far away from public health facilites do not come for services. Once the funding opportunity is available, the Department will submit the Community Health Center grant. We also work with communities that are situated farther away from health care facilities in our prevention work. We continue to work with the schools at Kagman Village and also within the village. We applied for the Home Visiting Grant which if approved will provide us with the opportunity to assist our families who reside in at risk communities.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	60608.0
Percent Below: 50% of poverty	19.1
100% of poverty	69.2
200% of poverty	82.0

Notes - 2011
Data derived from 2005 HIES

Number 11588 at 50% below. Pending verification from source, CSD Dept. of Commerce

Number 41912 at 125%. Pending verification from source.

Number 49693 at 185%. Pending verification from source.

Narrative:
As last year, we are reporting on the HIES 2005 survey. The data is indicating to us that our population cannot afford to pay for health care services. Again, this is why we continue with our outreach activities to provide the community with the knowledge and tools to live healthier lifestyles; eligibility assistance to our uninsured; and also bringing services out to the villages.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	21171.0
Percent Below: 50% of poverty	1.0
100% of poverty	1.0
200% of poverty	1.0

Notes - 2011
Total derived from 2005 HIES

Pending data

Pending data from source

Pending data from source

Narrative:
Medicaid Program works with the guidelines of 150% below the poverty level. We do not have accurate numbers to report on this health status indicator. We do have programs in the Division that work with poverty level guidelines but for adults. We also have programs such as WIC in which if a children are receiving food stamps they automatically qualify for WIC. One of the data we worked with to forecast how many students would be entering Head Start Program in the next year is WIC Program data.

F. Other Program Activities

Through our quality improvement work with the newborn hearing screening program we are discussing with other programs how to increase our collaboration to improve rates whether it is immunization, breastfeeding, prenatal care, mammography, etc and thus outcomes. For example, to reduce the percentage of babies that does not pass the hospital hearing screening we encourage breastfeeding to help eliminate fluid from the ears. Thus MCH and WIC programs have provided newborn hearing screening program with talking tips on breastfeeding and brochures. In return program staff is informing parents of this information when providing breastfeeding education. We are reviewing our data to see which age groups are getting pap test and mammography through the Breast and Cervical Cancer Screening Program. We will focus our efforts on that age group, including ethnicity that is not coming in for services.

We are working with our internal and external partners in putting together resources to develop a system for autism screening and referral for children. We have already increased our autism

awareness through media campaigns with our early childhood comprehensive system project.

MCH has supported H1N1 flu campaign as a member of the Risk Communication team and community outreach. We conducted mass immunization throughout the villages of Saipan, Rota and Tinian and mass media campaigns focusing on groups such as pregnant women, children, children with special health care needs, etc. We also visited summer camps and daycare centers to teach children about washing hands and proper way to sneeze and cough. We have a successful ongoing Kung Flu campaign.

MCH Program has been instrumental in providing assistance to the Office of Health and Vital Statistics such as in the implementation process of the birth certificate form to the 2003 standard form; training; equipment; etc. Please note that MCH data is provided by the Office.

The MCH Program continues to provide the community with telephone numbers and a contact for information. The first and primary is the MCH Program number that is ready to appropriately refer or assist callers. The ECCS Project has been receiving calls on early childhood. Our community can call any program/service directly. We provide the hospital operator staff with directory of all Division Program and the contact name again so that they can transfer call appropriately. Rota and Tinian residents can call Saipan free of charge. If for some reason staff from other programs are not in the office, lines are transferred so that for example MCH staff can assist the caller. Please note that all contact information is included in media campaigns.

Until the DPH website is fully functional, MCH Program has been putting information on partners' website such as WIC Program.

One major challenge we have encountered the past two years is the inability to contact families through telephone. Although we do have updated contact information majority of it is a cell phone number. When we call these numbers majority of the time we get a respond that there is no minutes to make the call. In other words, these cell phones do not have a 'plan' but are on prepaid minutes. In February we randomly contacted 12 clients for the different programs with a cell phone contact in a two week period and we were able to contact 38 (some of the phones were also turned off). This has impacted our work in tracking and follow-up and in conducting surveys. One of the recommended incentives from parent groups is prepaid minutes cards.

MCH participated in following activities:

- Celebrity Bagging
- Domestic Violence Walk
- Board Member of the Safe Haven Connecting Families, Inc. which operates the Family Visitation Center
- In collaboration with PSS, we conducted hearing screening to all students in the public and private elementary school
- Supported the Clean Air Act Bill
- MCH staff attended are trained on handling of hazardous materials
- First Responders Training and Preparedness Exercise
- Member of the Commonwealth Cancer Association
- Prostate Cancer Awareness Month
- Marianas March Against Cancer

G. Technical Assistance

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	477461	391518	477986		470757	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	448253	367567	965706		395500	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	316175	259264	191334		0	
7. Subtotal	1241889	1018349	1635026		866257	
8. Other Federal Funds *(Line10, Form 2)*	4775433	3915855	27200		518644	
9. Total *(Line11, Form 2)*	6017322	4934204	1662226		1384901	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	61405	50352	61404		21657	
b. Infants < 1 year old	61405	50352	61404		21656	
c. Children 1 to 22 years old	153480	125854	153480		285865	
d. Children with	158765	130187	158245		294527	

Special Healthcare Needs						
e. Others	764428	626831	1157040		164589	
f. Administration	42406	34773	43453		77963	
g. SUBTOTAL	1241889	1018349	1635026		866257	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		10000		94644	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	1344745		0		0	
h. AIDS	345366		1500		0	
i. CDC	2816096		1700		0	
j. Education	0		0		0	
k. Other						
CDC-EHDI	0		0		142000	
HRSA-UNHS/ECCS	0		0		282000	
HRSA-ECCS;CDC-ehdi	0		12000		0	
Region IX - FP	0		2000		0	
OPA Title X FP	174582		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	931417	763762	1226270		649693	
II. Enabling Services	74513	61100	98102		51976	
III. Population-Based Services	161446	132386	212553		112613	
IV. Infrastructure Building Services	74513	61101	98101		51975	
V. Federal-State Title V Block Grant Partnership Total	1241889	1018349	1635026		866257	

A. Expenditures

FY2009 Final Fund Status Report reported as total budget of $468,556 and total expenditure of $381,832 or 81%.

Component A, Services for Pregnant Women and Infants, was budgeted at $_25,890_ (6%) of the total federal award.

Component B, Services for Children and adolescent Health, was budgeted at $ _153,480_ (32%) (at least 30% of the total federal award to be utilized in compliance with the 30%-30% requirements).

Component C, Services for Children with Special Health Care Needs, was budged at $_158,765_

(33%) (at least 30% of the total federal award to be utilized in compliance with the 30%-30% requirements).
Administrative costs was budgeted at $_42,406_, which is 10% of the total direct costs of the federal grant awarded. According to OBRA 1989, not more than 10% of the total MCH Block Grant may be used for administering the funds. CNMI applied the 10% as Indirect Cost or Administrative Costs managed by the central government Department of Finance and Accounting. The Department of Finance and Accounting ensures that funds are expended accordingly and processes the Federal Financial Report (FFR) for all federal programs funded to the Division of Public Health.
Personnel and fringe costs were expended as proposed on the budget breakdown and the most of the MCH staff were ongoing FTEs with the exception of the two vacated positions -- Nutritionist and MCH Data Analyst -- which were hard-to-fill positions.
Supplies expenditures supported the costs of routine office -- supplies utilized in the administration office of the Division of Public Health, operational - outreach and public awareness supplies, clinical -- gloves, gauze, alcohol, and other supplies utilized in the clinics, and equipment supplies-- dopplers, one laptop computer, two desktop computers and a printer utilized by the MCH staffs.
Travel expenditures for DPH/MCH staffs -- Out-of-State Travel: MCH Epidemiology Conference, AMCHP Conference, APNLC Presentation, and MCH Block Review; Intra-State Travel: Wise Women Village Project meeting, Hinemlo-ta Training, Headstart Parent's Symposium, and Early Intervention meeting.
"Other" expenditures -- printing of pamphlets, brochures, flyers, and booklets; advertising of the Newborn Screening, Developmental Screening, and other MCH projects; dues paid to AMCHP and NAPHSIS for memberships.

FY2010 Federal Financial Report (FFR) will not be final until 12/31/10

B. Budget

FY2011 budget proposal of $470,757, consisted of:
Component A: $25,890; Component B: $153,480 (33% of the total federal budget); Component C: $160,510 (34% of the total federal budget); Administrative (Indirect) Cost: $42,796 (10% of the total direct costs); and the remaining amount allocated to Supplies: $24,202; Travel: $35,268; and Other: $28,611.
The State MCH match budgeted at $395,500 is comprised of State General Fund dollars which will comply with the required FY1989 Maintenance of Effort amount. The requirement of the 3-4 match of three (3) state dollars for every four (4) federal dollars or 75% of the federal total budget.
The Federal-State Title V Block Grant Partnership is $866,257. Out of the total, $649,693 or 75% was distributed to Direct Health Care Services; $51,976 or 6% to Enabling Services; $112,613 or 13% to Population-Based Services; and $51,975 or 6% to Infrastructure Building Services.
The other Federal funds under the control of the MCH Coordinator responsible for the administration of the Title V program) are SSDI $94.644. CDC-EHDI $142,000, HRSA-ECCS $132,000 and HRSA-UNHS $150,000 and to $518,644. The overall State MCH budget total is $1,384,901.
An attachment is included in this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.